WHERE ARE THEY NOW?

A FOLLOW-UP STUDY OF 314 MULTI-HANDICAPPED BLIND PEOPLE, FORMER PUPILS OF CONDOVER HALL SCHOOL

by

S. O. MYERS

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WHERE ARE THEY NOW?

A FOLLOW-UP STUDY OF 314 MULTI-HANDICAPPED BLIND PEOPLE, FORMER PUPILS OF CONDOVER HALL SCHOOL

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ACKNOWLEDGEMENTS

Before acknowledging the help I have received in carrying out the research, I would like to make one observation concerning the staff of Condover Hall School. We were not a group of people dedicated (in the emotive fashion in which this word is often used) to the welfare of seriously handicapped children. I consider that we were a fairly normal cross-section of the general population who, given the encouragement to make individual contributions in a democratic atmosphere, were able to develop a lively community in which the children were able to develop personal skills, a sense of self-responsibility and a considerable amount of enjoyment of life. It is an encouraging fact that, in workers for the handicapped, selfless dedication is not necessary. Given the opportunity, ordinary people can provide compassion and love, modified and strengthened by an objective, professional approach, which ensure good standards of care and education.

With regard to the field work of the research, I acknowledge with gratitude the help I received from:-

ex-pupils and their parents, with their readiness to receive me and to express opinions frankly;
the staffs of hospitals, day centres, residential homes, factories, etc., especially those who are caring for ex-pupils who are integrated into facilities for sighted people;
many friends who expressed interest in the research and who, I hope, will not be too disappointed with this report;
the Westcroft Trust, who, on two occasions when financial help was urgently needed, supplied the necessary money;
the Royal National Institute for the Blind, especially its Education Officer, Mr. Colborne Brown and his staff, from whom I received much friendship and encouragement while I was at Condover and during the research.

I express special thanks to Dr Tobin and the staff of the Research Centre for the Education of the Visually Handicapped. It was a great pleasure to be a member of the team of the Centre in the early days of its development. My report has needed much pruning and revision and I have been much indebted to Mrs. Jennifer Whittaker, who did so much to produce a sense of order from the chaos of notes, alterations and frequent re-writings, and to Mrs. Eileen Hill who helped in the production of the final draft for publication.

Throughout the report I frequently use the word 'I', where I should have used 'we', since my wife accompanied me in nearly all the field-work visits, was a most helpful auxiliary secretary and was a great source of encouragement.

S. O. Myers.

PREFACE

This document is the report of an investigation carried out by the first head-teacher of Condover Hall School for Blind Children with Other Handicaps. It describes the genesis of the school, the 'philosophy' of education that evolved within its community of teachers, child-care staff, and visually handicapped pupils, and then goes on to show what has happened to more than 300 adults who spent most of their secondary-school years at Condover. Unlike most reports, it is written in 'first-person' style and, as such, its statistics and facts are imbued with qualities of involvement and immediacy normally lacking in enquiries of this kind. Condover was, and is, a school known throughout the world for its pioneering contribution to the education and welfare of additionally handicapped blind children. Much of its success is attributable to the far-sightedness of its founders, the Royal National Institute for the Blind, and to the dedication and professionalism of its staff. They, however, would be the first to affirm that it was the leadership of Oscar Myers that generated this success. In undertaking this follow-up investigation, he has been concerned with discovering the facilities and services now available to multi-handicapped blind adults, and with examining the extent to which the school's curricula had met their needs and prepared them for life outside it. As the first headteacher, he was able to bring to this enquiry an understanding of their educational and social background against which to set their present achievements, expectations, and way of life.

We hope the report will be of interest to visually handicapped people; their parents and guardians; teachers; social workers; the staff and governing bodies of hospitals, institutions, and occupation centres; and, indeed, to anyone with a concern for the way in which we make provision for the care and employment of the handicapped. Some readers will, however, have rather specialized interests; the list of contents allows them to identify those sections related to their needs. Nevertheless, even the specialists should read Chapters 1 and 2. It is here that an account is given of the development of the Condover community — its aims, its organisation, its methods — and of the report's system of classification of handicaps. It is hoped that the re-printing of the classification system on the bookmark will act as an aide-mémoire; the justification of the system, and its relation to other commonly-used classifications, are detailed in Chapter 2. This chapter should, therefore, probably be regarded as essential reading for all users of the report. It constitutes, in addition, a valuable introduction to the whole theme of blindness and multiple-handicap since it expresses some part of the wealth of practical experience gathered by the author during nearly forty years of work with blind children and adults.

Chapters 3 to 7 are the quarries to be mined by those with specialist interests. Here they will find the raw material that will add to their knowledge of the current status and needs of multi-handicapped blind adults. They will note the disparities in provision of services throughout the country (despite the statutory obligations), the enterprise of individual ex-pupils, the innovations brought in by local and national charities, and the dead weight of inertia associated with lack of adequate finance. Chapters 3, 5, 6, and 7 deal with hospitals, day occupation centres, residential facilities, and home placement of those with no occupation open to them. The tables of statistics summarize the present situation; the case-histories give insights into problems and expectations. Despite the 'successes', there is evidence in these chapters to substantiate the charge that all too often a satisfactory schooling is not built upon by appropriate, continuing assessment and training procedures. Some

men and women are in hospitals when they could be enjoying more self-directed, independent lives. Others are in occupation centres when their abilities would indicate they could be considered for outside employment. Even for those whose current placement seems the most satisfactory available, there are questions to be answered about facilities for extending their mobility and communication skills, social competence (self-care, responsibility for pocket-money and spending, household duties), leisure-time interests and opportunities, and, of supreme importance to ageing parents, about suitable provision for the time when the less-independent, more severely-handicapped are eventually bereft of family support. In these four chapters, the evidence is amassed and, where appropriate, recommendations put forward and examples cited of successful attempts to solve these very problems.

Chapter 4 (Employment and Occupation) gives information about those former pupils who may be considered as fully independent adults, earning the 'rate-for-the-job' and supporting themselves and, in some cases, their own, new families. Here we have case-histories that inspire us through accounts of how problems have been overcome. But there is, too, a proper emphasis on the importance of occupation for those less-able men and women who can nevertheless derive benefit, personally and socially if not economically, from the daily exercise of leaving home or hostel, and carrying out appropriate, repetitive, manual tasks.

Chapter 8 (Deaf-Blindness) will perhaps principally be of interest to parents and educationists since it discusses the teaching of deaf-blind children in the special Condover unit known as Pathways. The problems of the 'rubella' children are also considered in this chapter, and their future care and employment prospects are looked at in the light of the placements of the 24 deaf-blind adults who represent a sub-group of the enquiry's total population of 314.

Chapter 9 brings together some of the major findings and recommendations. If it is read in conjunction with the first two chapters, it can provide an overview of the whole report, leaving readers to turn then to other chapters for more detailed information and to capture, from the case-histories, something of the substance and reality of the lives of people whose handicaps are only partially alleviated by the services we as a community are still trying to set up.

In commending this report to laymen and specialists, I am conscious of the debt due to Oscar Myers from those of us who have been fortunate enough to be his colleagues. He has brought to this investigation, and to its written account, the same qualities that have made Condover so universally admired: commitment and dedication, tempered by objectivity and open-mindedness. In the Research Centre we also acquired two workers for the price of one, because Condover and this enquiry gained much from the gentle and unstinting service of Rene Myers. The Condover staff and former pupils know this. I am happy to make this public acknowledgement of it.

M.J. Tobin,

April, 1975.

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CHAPTER 1

CONDOVER HALL SCHOOL FOR BLIND CHILDREN WITH OTHER HANDICAPS

THE FOUNDING AND DEVELOPMENT OF A COMMUNITY

In writing this report I have been faced with the problem of whether to write impersonally or whether it would be better to write in the first person. As I have been completely involved in all the ideas, events, and procedures which I shall be discussing, it seems much too artificial for me to employ an impersonal style with much laboured use of the passive tense. On the other hand, I would like to think that, where it is appropriate, I could describe and discuss some subjects quite objectively. I do not wish to avoid expressing any intensely held opinions, emotionally over-loaded though some of them may be. I write from the point of view of someone who has really lived for many years with seriously handicapped children, and not as an impersonal observer.

What I have in mind, in this introductory chapter, is the presentation of a series of ideas and procedures concerning the education of multi-handicapped blind children, hoping that, here and there, I may mention something which could be useful to other people working with handicapped children. Any excessive personal claims for the invention of a system of education would be quite wrong, especially for the following reasons:- perhaps the most important theme underlying the Condover story is that a group of quite ordinary people, can, co-operatively and democratically, devise and develop a good way of life for a group of very handicapped children. Although, somewhat immodestly, I am prepared to admit that I played quite an important role in the school, its planning and its functioning, many members of staff also played vital parts. Their contributions were made, not only to the daily life of the school, but also to what could be called, rather grandiosely the developing philosophy of Condover. Because of my firm belief in co-operative staff action, I have often observed with amused disbelief the bombastic way in which many headteachers, who are probably nice, modest people can talk in lordly fashion about what "I" do in "My" school. This is, therefore, one of the reasons why I have some misgivings about the use of the first person, singular. Incidentally, there are some difficulties about using the plural "we", as I often do, together with references to Condover as "our" school, which I realised some time ago when, after having written in this vein to our headquarters, I received an exasperated comment about what right had I to use the regal "we"!

I hope that I have resolved the personal dilemma about the style of this report by writing most sections quite boldly in the first person. Readers will realise that these sections are based mainly on personal opinions, beliefs, experiences, and sometimes, it may be thought, on personal idiosyncracies or near-obsessions. In other sections I try to give impersonal, objective descriptions of the school in action and of a research survey of what has happened to Condover boys and girls since they have left school. In this dual approach method, readers will receive information at two levels, with a series of factual presentations and an accompaniment of personal comments.

The first section of the report, having begun in the first person, will continue in this style and will aim to show my frame of mind when I faced the challenge of having to open a completely new school.

Before I came to Condover I had worked with and taught blind children of normal ability for sixteen years. During the last eight of these years most of my teaching had been carried out with the top class of a secondary school. For the last four years I had to initiate a scheme of further education for older pupils, aged 16-20, who were working in the vocational training department of the school. My interests, therefore, lay with the older and more able children,

and I tended to think of the less able children as something of a bore. I am talking of that era, before the implementation of the 1944 Education Act, when additionally handicapped blind children, especially the "backward" were dismissed from school as "ineducable". Like most other teachers I considered these additionally handicapped children to be a hindrance to the progress of the other more able pupils, so they were declared to be unsuitable for education. Fortunately for them - and for many other handicapped children - the people who drafted the 1944 Act, and Parliament which made it law, had a more compassionate attitude towards these children, who, at that time, were denied education.

One very early practical application of the Act was the decision to open a nationally based school for additionally handicapped blind children. The National Institute for the Blind, now the Royal National Institute for the Blind, was asked to take responsibility for this new school. It did so, bought an Elizabethan mansion in Shropshire and advertised for a Headmaster. The financial arrangements for the Head were attractive and the advertisement indicated that the man appointed would have considerable freedom in the staffing and organisation of the school.

The number of blind children now at school in England and Wales is quite small, approximately 1,200. Consequently the number of schools is small and so, therefore, are opportunities for promotion for teachers. Hence, in 1947 when the situation was not all that different I was faced with quite a problem when this post of Headmaster of Condover Hall was advertised. The possibility of other headships becoming vacant was unlikely. On the other hand, Condover was to concern itself with blind children with quite severe handicaps, the majority being very intellectually retarded - hardly my cup of tea! This sounds quite insufferable, as if I was not going to waste my talents in teaching the nearly ineducable. However, I am trying to be truthful and I hope I am making the point that I felt no "call" to work for these "poor neglected children". I can also quite honestly say that, when I first started to work with blind children, there was also no feeling of dedication on my part. It was simply that I gained financially when I became a Resident Supervisor. The fact that I found out that I really enjoyed this unusual work - and was soon able to start teaching blind children too - was a quite unexpected bonus. Nevertheless, at Condover there would be the interesting challenge of an opportunity which does not come very frequently to teachers. It was to be an absolutely new school. I made further enquiries and it was confirmed that the Royal National Institute for the Blind would give the Headmaster a remarkably free hand with the organisation of the school, the type of staff and their appointments, etc.

There were some pleasant incidental attractions about the post. Condover Hall is an Elizabethan house dating from the end of the 16th Century. It had been quite lavishly modernised in the 1920's, it stands in extensive grounds with large lawns, some rough woodland and an interesting stream, and it is situated on the edge of a pretty Shropshire village. My wife agreed I should apply and Condover did seem to be a grand place to bring up our family of three young boys. So I applied for the post and was fortunate to be chosen.

My employers appointed me eight months before the school was to be opened and they positively encouraged me to make as many educational visits as I wished. I had worked with blind children of normal ability and had enjoyed it, but the objectives there had been clear. We had to provide an educational programme adapted to the special needs of blind children, but it was very similar in content to the syllabus for seeing children. For blind children of normal ability and without serious additional handicaps, it is quite realistic to have as the

principal objective that the majority of the children should become economically self-sufficient and live in normal society. However, it would certainly not be realistic to have such an aim for the seriously handicapped boys and girls who were to be the pupils of Condover Hall School.

It took me some time to realise to the full that the eight-month period of preparation which I had been granted - a kind of sabbatical leave - was a heaven-sent opportunity to think seriously about the objectives for the new school and devise possible methods of realising them. In total I made 35 visits. At no time did I find a ready-made plan, not even a partial one, which could be adapted for Condover after modification for the special needs of blind children with other handicaps. Rather it was a matter of my being grateful for a whole series of ideas, opinions, tips, insights, etc., gained from observations and discussions. I must state too that there were some things I saw which I felt we must, at all costs, avoid copying! The final outcome was that I was able to evolve a tentative plan of action to put to the staff when the school opened.

There were four interlinked subjects which were very much in my mind before, during, and after my period of preparatory study:-

(a) the creation of a home-like residential atmosphere which would also have educational significance;

(b) some form of democracy for staff and pupils;

(c) an educational programme for the children, based on activity and experience;

(d) a combined, co-operating, staff.

In discussing these topics below, I propose to set them against the history and background of my own previous experience of working in a residential school for normal blind children.

(a) <u>The Residential Community</u>

The creation of a residential organisation, while it must involve some formal procedures and regulations, should nevertheless produce acceptable and happy conditions in which handicapped children could live - children who, through no fault of their own, are compelled to live away from their homes. I have to admit that I had some very strongly held opinions on this subject, based on my experiences as a teacher in an "institution". At first, I had accepted the conditions for the blind children at the school where I began my experience of residential life as something quite normal. I think my reaction against its artificiality began when I started thinking of our attitudes to the children's parents. They were only welcome at school for formal occasions and never saw the school in action. The staff had no contacts with parents and, indeed, showed no desire to meet them. However, I had the emotionally charged feelings of a young father whose first son was born at that time and I had the obvious reaction:- if our boy were blind, would I wish him to live at our school? This was, of course, a rhetorical question expecting the answer "No!". My feelings of anti-institutionalism had led to my resistance towards the old-fashioned impersonal regimentation, to some extent conditioned by the awful building, and the over-regulated life for the boys and girls which could have been changed. I was beginning to realise the power and inertia of tradition which could lead to the unquestioning continuation of out-dated, and to some extent, inhuman practices. A new school should not be encumbered with unnecessary restrictive practices.

I would like to develop this theme and examine some of the things which exasperated me, mainly because we teachers of the 1930's and the 1940's accepted as normal some quite ridiculous situations and procedures. As I carry out this very personal examination, may I invite anyone involved in the education of handicapped children - perhaps, also, in so-called "normal" education - to take a critical look at their own ways of behaving? No doubt all the strange practices of 30 years ago have disappeared - or have they?

As I have said, I began my experience in the education of blind children as a Resident Supervisor, one of a team of three men responsible for the leisure-time activities of 65 blind boys and young men aged 11-20. The rota of duties was simple: we each did a day's duty, alone, every third day. A day's duty began at 7.15 a.m. when the man on duty woke all the boys, who slept in dormitories with 20-25 beds. He 'chivvied' them around while they washed hands and face downstairs in the bathroom which had a relay of taps running into long troughs. (The boys had been supervised the previous evening in groups of 20, while they took a "strip wash".) They came upstairs again to finish dressing and then down again to clean shoes under a lean-to roof in the playground. These activities came to an end when a bell rang. The boys aged 11-16 "lined up" in a playroom to have hands, faces, knees and boots inspected for cleanliness. The pupils then walked in line, in silence, down the corridor to the dining room. Here they joined the girls for breakfast (sexes segregated, of course), the pupils sitting on long benches, six or eight pupils per bench, at long, oil-cloth covered tables. Breakfast took place in silence, as did all meals. Ringing of bells, lining up in silence, walking in lines to assembly, classes, and meals continued till evening.

There were some organised activities in the evenings - scouts, guides, P.E., occasional swimming, a Literary and Debating Society and, during the winter, a fearsome programme of football games organised on a league basis. The football was played in the dark with a full-size football, to the lace of which two or three flattened tins were attached with wire. The tins rattled loudly when the ball was on the ground and, usually, less loudly when the ball was in flight. Occasionally the tins remained silent in flight and thus "disappeared", sometimes appearing again when the ball struck a player or even the Resident Supervisor who acted as referee. Games could not be played in bright moonlight because this gave too much advantage to boys with a little sight. Finally the City Council unwittingly put an end to the football when a tall new street-lamp was erected outside the playground and thus flood-lighted the football pitch. This pitch, by the way, was approximately 40 yards by 20 yards, was made of asphalt and was the only outdoor playing space for 65 boys and young men!

There were three recreation rooms, one each for Juniors, Intermediates, and Seniors. The Seniors were allowed to smoke in their room - nowhere else. They had the few easy chairs which were available for pupils, the young boys having to use classroom chairs. The Seniors' room was partitioned into two, the so-called quiet room also being a day-time classroom. The Intermediate's room also doubled as a classroom and this led at times to definite difficulties between the class teacher and the resident supervisors. No comfort, no privacy for adolescents and young men who spent more than three quarters of each year in these conditions, away from home! The poor Juniors had an almost completely bare room which was called the play-room. A few games, mainly dominoes and cards, were kept in the Staff room. Some nights a supervisor's duty seemed to be mainly concerned with keeping some semblance of peace in the playroom.

I am sure I have said nearly enough to demonstrate why I, and a few other people, had come to be very anti-institutional in our attitudes. I wish, however,

to pursue my inspection of the old system a little further, inviting anyone who reads what I am writing to inspect their present conditions of work. Are you, unthinkingly, allowing unnecessary regimentation and lack of freedom for children spoil their happy enjoyment of educational opportunities? Also, can you see ways in which your school organisation and staff procedures are unsatisfactory and could be improved?

Let us go back, then, to the Institution. The regimentation was carried on into the week-end. The senior boys, fortunately, were allowed some freedom and could book out for the afternoons and, sometimes, for the evenings. The senior girls had only a very restricted version of this freedom. Unless the weather was very bad, all boys and girls under the age of 16 were compelled to go out on those terrible crocodile walks. I remember being reprimanded when it was found out that I had taken my group of boys a shorter distance than usual and had allowed them to play in a park and use the play apparatus. I suppose the bogy of accident insurance must have led my Head - in many ways very progressive and humane - to reprove me instead of praising me for giving the boys wider experiences.

On Sunday mornings the whole school, in lines of course, one line for the boys and one for the girls, were compelled to walk to the local Church of England church. Here, boys segregated from girls, we sat apart from the main congregation. There were no modifications of the service which might have interested the boys and girls, who formed at least two-thirds of the complete congregation. What an example of thoughtless persistence of a traditional exercise!

Children's letter-writing home took place on Thursday evenings. Since the boys wrote braille and most of their parents could not read it, the resident supervisor who happened to be on duty was responsible for a great deal of hurried secretarial work. On the three-day rota this only occurred for me on one Thursday in three. I found this letter-writing a boring chore - urging some boys, who had a natural inclination not to write anyway, to write at least two or three sentences; curtailing the efforts of the boys who wanted to write a lot; editing and, indeed, censoring some letters. And this letter-writing was the only contact the boys had with home during term-time apart from very infrequent Parents' Visiting Days. Nowadays no doubt all schools allow pupils to have uncensored conversations with their parents and friends when they can complain about the food, the unfairness of certain members of staff, the boredom, etc. In the days of supervised letter-writing, no topics of this nature leaked into the staff-controlled children's letters. Presumably the boys and girls made up for some lost time when they were at home. Strangely enough parents rarely complained and a contributing factor to this inaction was the authoritarian attitude of the school authorities towards them.

My last point is the boy-girl situation. The school was reputed to be co-educational, but this was really a mis-nomer. In leisure-time the boys and girls were almost completely segregated. A few formal, well-supervised dances were held, there was an Annual Christmas play with pupil actors and actresses and there was a mixed choir. There were no opportunities for relaxed, unsupervised meetings between boys and girls. There were no conscious efforts made to use, for real educational objectives, the fact that boys and girls were living in the same school. Instead this fact was a nuisance causing a good deal of worry and supervision for the staff to ensure that segregation was observed.

By 1939 cracks in the restrictive practices which I have described were beginning to appear. Then came the war with the evacuation scheme for our school and this dealt effectively with the co-education problem at any rate:- the boys were sent to one place and the girls to another place 20 miles away. Fortunately, however, the boys and girls each lived in large country houses with smaller

rooms than the city institution. Although the rooms were the large ones of Victorian mansions, they were more domestic in nature than the school dormitories and classrooms. The traumatic experience of evacuation together with a certain air of improvisation of life in the country houses and the fact that staff and children lived more closely together than in the city made possible a more relaxed a domestic life. I was particularly fortunate in that I had to take charge of the girls' section and it was reasonable to expect that the girls would help in the domestic chores of the school. Also, as part of our enforced improvisation, we had to recruit house staff who had no experience of life in an institution. Life was carried on with a minimum of regimentation, a considerable amount of freedom for the girls, and some possibilities for them to participate in the planning of the life of the school. With little conscious planning a very pleasant community spirit developed, in which an enjoyable leisure became a series of educational experiences in social and personal life.

At the end of the war the school re-assembled at the old institution, though the senior boys and girls, who had lived during the war in a vocational training establishment in the city, remained there. The changing attitude towards the management of children in residence was not confined to our school. In fact, very significant changes had been taking place elsewhere, as is shown by the following episode. Some members of our staff, still a minority, felt that pupils should have occasional week-ends at home during term-time. Various objections were raised, mainly based on the obstinate persistence of the traditional attitudes and procedures. Finally the Ministry of Education was consulted and they sent a small deputation of inspectors to consider the matter. I must admit that I, being naturally a supporter of the week-ends at home scheme, was very pessimistic about this inspectorial visit. I still remember, with glee, the remark of one inspector who was, significantly, I suppose, a married woman with children of her own. I had taken her to see our junior boys' dormitory, with its 25 beds spotlessly clean and beautifully tidy. She said, "If these are the conditions in which the children live, I would recommend that every child should go home every weekend." In the sphere of education of blind children we have been blessed with a series of enlightened H.M.I.'s, particularly in the period following the 1944 Education Act.

(b) Democracy

At this time, shortly after the war, I had proposed to the staff a form of School Government, with pupil participation, and we were able to establish it. The scheme had limited objectives. The school meeting of staff and selected pupils formed sub-committees of pupils, which were, in effect, clubs. When they had presented an outline plan for its use, each of the clubs was allocated £10 per term. After this they had complete control of the spending. I had in mind that further developments would follow with pupils having the right to discuss some matters of school policy.

At about the same time, mainly at the inspiration of a teacher colleague, we, the group of three teachers who had developed the further education scheme in the vocational training department, founded a Students' Union there. Because the students were older, aged 16-20, it was possible for them to go further with policy discussions. This Union also had planning control of the finances which they were allocated.

As far as I can remember, from 1931, when I joined the staff of the school until 1939, we had held one staff meeting. It would be more exact to say that this staff meeting was summoned - the only business being an announcement that, because of a national emergency, we must accept a cut in salary. In 1942 I had

been appointed Deputy Head and when the school re-assembled in the Institution after the war, this seemed a good time to try to establish some system of Staff Meetings. The Head agreed that I should be responsible for the meetings and all proposals for action were presented to him for his approval or veto. A few meetings were held, but apart from the major matter of the founding of the School Government scheme, only matters of detail, e.g. timetables and curriculum, were discussed. I hoped that, later, staff meetings would make decisions on school policy.

It was during this period of development that I had to decide whether to apply for the post at Condover Hall. There were some frustrations in being Deputy, and I was hoping that sometime I might be appointed Head somewhere, and I could work out some of these principles of democracy without the retarding effect of established practice. The decision about applying for the new post was far from easy to make. The dilemma was this: on the one hand was I to give up working with staff and children whom I knew well - and liked - but where I did not have complete responsibility? The alternative was that the new school would be populated mainly by children many of whom, previously, I would have considered to be ineducable. I had serious misgivings about the fundamental matters of my own personal relationships with such children, about the possibility of even teaching them anything at all and, very specially, about how the children could participate realistically in projects like School Government.

(c) Activity and Experience

Another idea in which I had been interested seemed to have relevance to the education of severely handicapped children. I am referring to the ideas of those educators who were advocating "Activity" methods in Primary Schools. The name of the method seems to vary as the years pass, but "Activity" was the name then used to describe a curriculum based on environmental study combined with learning through activity and experience. It appeared to me that normal blind children, who live in an environment which is restricted by the effect of their handicaps, would profit from activity methods. To allow all handicapped children opportunities to gain educational activities and experiences outside the classroom and the school seems very important. I had, in fact, experimented in a limited way with Activity methods with normal blind children and much of our school life during the period of evacuation had been tinged with these methods. I was aware of the arguments sometimes put forward that Activity methods could hinder educational progress for children who are, in any case, considerably retarded because of their handicaps. In my opinion this was a narrow interpretation of educational progress and was really only concerned with academic progress. I realised that few Condover children would make any progress in academic education and there would certainly be no pressures because of examinations. Illiteracy could be accepted and not be equated with ineducability. It appeared that a curriculum based on children learning through activity and experience could well be the ideal educational programme for a school of multi-handicapped blind children.

(d) One Combined Staff

I had seen, at first hand, the ill-effects on the education and welfare of children in a residential school of a system in which the classroom education was nearly completely divorced from the leisure-time and residential aspects of the children's life. Though, nominally, the Head Teacher, who was called the Principal, was responsible for all aspects of the school life, there was a definite division between the teaching staff and the Matron's staff. Even when a teacher was also a resident supervisor the gulf between residential and classroom education remained largely unbridged. The residential child care staff was

grossly undermanned and overworked. The ladies could only deal with material things - clothing, meals, cleaning and the like. They had neither time nor opportunity to give the continuing warmth of affection and support which children need when they spend three-quarters of their time away from home. The resident supervisors had only time to carry out the duties implied in the title by which they were known.

General Development of Educational Services for Multi-Handicapped Blind Children

I hope that what I have written so far gives some indication of my attitudes and thinking when, in 1948, I was faced with the challenge of opening the new school at Condover. Before I begin to describe how theory became practice it is essential that I should deal with the topic of the children's handicaps.

One of the consequences of the 1944 Education Act was the extension of education to considerable numbers of seriously handicapped children previously thought to be ineducable. Among these children were blind children who had such serious additional handicaps that they had been deemed unable to profit from the educational programmes of the existing schools for the blind.

From 1931 the Royal National Institute for the Blind had organised and maintained a small school for blind children with other handicaps at Court Grange in South Devon. It was, therefore, natural for the then Ministry of Education to ask the R.N.I.B. to set up extended facilities for the education of children of this type on a national basis. It was thought that one school, centrally situated, would serve this purpose and the R.N.I.B. undertook to found such a school at Condover. This it did, and the new school was opened in May, 1948. The children at Court Grange, who had been described as "retarded", were incorporated into the new school and the range of handicapped children who were offered admission was widened to include those who had physical and emotional handicaps.

The number of multi-handicapped, visually-handicapped children available for education was unknown but it was thought that 60 school places was a reasonable estimate and this would include blind and partially sighted. The age range would be from 7-16. Within four years the number of places had been increased to 72 and admissions were restricted to 'educationally blind' children. The school continued to have a long list of children awaiting admission so that in 1959 the R.N.I.B. opened at Rushton Hall in Northamptonshire a primary school for multi-handicapped children aged 7-11. Condover Hall became a secondary school dealing with children aged 12-16 or 17.

An experimental unit for four deaf-blind children was opened at Condover in 1952. This led to many enquiries about possible education for other deaf-blind children so that, in 1959, the R.N.I.B. opened the specially-built department for 16 deaf-blind children at Condover, which is known as Pathways, later extended to take 25 children.

During the period of the development of facilities for multi-handicapped blind children arising from the opening of Condover Hall School, there was a change of policy concerning the system of Sunshine Homes for Blind Babies, administered by the R.N.I.B. Increasing support is now given to the parents of blind babies so that the children can be maintained and educated at home until at least the age of five. This is usually effective and desirable for children without severe additional handicaps. Sometimes, however, multi-handicapped young children are a tremendous strain on their families. This explains why Sunshine Homes nowadays are largely populated with multi-handicapped blind children,

whereas in the 1940's most of the blind babies in the homes were reasonably "normal". By 1970 the R.N.I.B. was providing residential accommodation for nearly 250 multi-handicapped blind children of ages from birth to 17. Ninety-five are at Condover, 45 at Rushton, and about 110 in Sunshine Homes.

Multi-handicapped Blind Children at Condover

The official title of the school is Condover Hall School for Blind Children with Other Handicaps, which is a clear enough description. I use the term 'multi-handicapped blind children' to emphasise the multiple nature of many children's handicaps.

Chapter 2 of this report is devoted to a description of handicaps and their varying severities and this can be consulted by any reader who wishes to know something about the handicaps in more detail. It is, therefore, unnecessary to repeat this detailed information in the present chapter but, nevertheless, I should write something now to explain the children's difficulties. A summary of the grading scheme of the severity of handicaps, which I use throughout the report, is printed at the end of Chapter 1 and, for ease of reference, a bookmark is provided with a reprint of this summary. I invite readers to use this bookmark now as I present statistics of the 393 children who were admitted to the school from its opening in 1948 and had left by the end of 1970. These former pupils have been the subjects of my research survey. Two hundred and thirty-four were boys and 159 girls. At the time of admission to school the children's main handicaps were as shown below:-

Visual Handicaps		Intellectual Handicaps		Physical Handicaps		Behaviour Handicaps		Epilepsy	Deafness	
P.S.	95	A	149	a	26	m	71	72	d	22
P.B.	138	B	121	b	41	M	69		D/B	31
B.	160	C	61	c	25					
	393		331		92		140	72		53

I have not enumerated speech defects in the above list but, although we had many children handicapped in this way, at least 50, the defect was usually associated with other conditions, particularly physical handicaps and severe physical handicaps. Speech in the deaf-blind children was absent or very defective and I could have listed another 30 children as being dumb or having gross speech difficulties. Two other important conditions associated with more obvious major handicaps have been omitted: I refer (a) to that clumsiness which can be very handicapping and which is often referred to as minimal cerebral dysfunction and, (b) an exceptional inability in some totally blind people to build up that system of sensory compensation which is eventually developed by most blind people. My statistics are simply given as a justification of my use of the term 'multi-handicapped'. A statistical presentation of 'disembodied' handicaps, their variety and severity, has some limited usefulness and I provide information of this nature throughout my report. Such statements, however, are very far from being descriptions of living people.

My aim is to try to describe real children and adults who are multi-handicapped - people whom I know. An important task has been to describe how a variety of handicaps are combined in individuals. In different chapters of the report, where the numbers of subjects are of restricted size, I use various forms of tabular presentation to show this multiplicity of handicaps. This certainly gets nearer to individual people but does not take into account personal

characteristics, the life situation, etc. Throughout the report, therefore, I have used case-studies of varying length, hoping by describing a selected number of subjects to be able to present a living picture of the whole situation of former Condover pupils. In my enthusiastic desire to present a complete picture I had prepared a script which mentioned all individuals but, in order to make a coherent presentation with a minimum of confusion, I have had to carry out a considerable amount of selection and pruning. Nevertheless I still rely a good deal on the use of case-studies, sometimes informally and almost incidentally but, at other times, I use a more formal selection of studies to illustrate general situations or specific points.

Theory into Practice

The rest of this chapter will be an account of the basic features of the school organisation which the staff and I - and the children - were able to establish at Condover.

A Meaningful Community

I did not start at Condover with the definite objective of setting up a meaningful community of a certain pattern, but after less than two years this description could have been given to the organisation we had developed. In describing a school as a meaningful community I mean an organisation whose function is understood by all its members - children and staff - all of whom realise that they have an important part to play in the community and can take part in decisions concerning its procedures and policies. Such a community could be fairly easy to establish as far as staff are concerned, but how could this be achieved with the children, the majority of whom would be intellectually handicapped? With them the community spirit would have to arise from the actual life we provided for them to live in the school. Four organisational features eventually formed the unifying framework within which the community functioned:- the Family System, Staff Meeting, School Assembly, and a Special Sunday Service.

The Family System

First I will present a short historical outline of the development of the family system as far as numbers are concerned. This will clear the way for discussion of the more important personal, social, and educational aspects of the organisation.

We were fortunate in having only 25 pupils during the first term. Only a few members of staff had previous experience of residential school work and this I found to be a positive advantage in our efforts to provide a homely atmosphere for the children. Before the opening of the school this first group of staff were in full agreement that we should have some form of family system. During the first term discussion and planning took place so that, at the beginning of the second term when the number of children increased to 52, we could start immediately with five families. The 27 new children came from Court Grange School which then closed. Several members of staff came with the children. I had kept these staff members aware of the developments at Condover and all were prepared to support the family idea.

The next term the number of pupils increased to 60 which gave us five families of 12 children. This remained the standard size of a school family until 1964. In 1950 12 more children were admitted and a family of 12 lived in a fairly large house in the village.

The experimental unit for four deaf-blind children, started in 1952, developed on a family basis in former stable-buildings pleasantly adapted for school use. When this unit was extended and Pathways was established, the new purpose-built accommodation was provided in a pair of semi-detached houses, each section providing family-type living conditions for four children and their staff. The previous experimental unit became available in 1964 for a main-school family. The village house continued to take 12 children but the 60 children in the Hall were divided into six families of 10 children.

Then, in 1968, the building began of new flats, each for families of eight children, and occupation of these commenced in 1969 and was completed early in 1970. Each flat has three children's bedrooms: two for three children and one for two children. There is a small kitchen and a living space divided into dining and sitting room areas. The family mother and her assistant live in the flat. All meals, except mid-day lunch, are prepared and served in the flats.

Although the provision of the flats has given almost complete reality to the family living idea, it should be remembered that for about 20 years the majority of the children lived in the large Hall. The provision of separate family units was not feasible there though the facts that bedrooms were fairly small compared with institution dormitories and that five rooms were available for leisure activities helped with the family arrangements. Nevertheless there had to be a considerable amount of communal living, e.g. for eating and leisure time. Some of the family arrangements and practices, which I shall mention below, are much easier to carry out nowdays. Nevertheless, the family organisation was an undoubted success in the somewhat more difficult pre-1969 conditions.

Objectives and Functioning of the Family System

(i) Children in Families

When the system began a staff meeting decided that all families should have boys and girls and that the ages of the children and their handicaps should be mixed in each group. The staff meeting ensured there was a fair distribution of visual and other handicaps among the families and that each family had its proportion of 'easy' and 'difficult' children. Normally children stay in the one family all their school life and only very rarely has it been necessary to change a pupil's family because of incompatibility. After several years the replacement of leavers by new pupils led to some imbalance of handicaps between families. The staff decided that I should personally make a complete re-allocation of children to families, a procedure I carried out twice.

(ii) Staff in Families

The family mother is the most important figure in the family. In practice some mothers have been quite young and inexperienced in child care. This was remedied to some extent by the fact that all members of staff who have any dealings with the children are appointed to a family. Senior members of staff, teachers in particular, guide and advise the mother where necessary without themselves dominating family life. People's personalities vary and, during the school's life, there have, of course, been variations in the quality of relationship between teacher and mother. Inter-personality difficulties have occurred but, fortunately, these have been infrequent and mostly not of a serious nature. If I were asked to name three features of the Condover organisation which have pleased me most, one would certainly be the natural way in which mothers, teachers, and other staff have co-operated in the family system. The family duties of each small group of staff have helped to ensure that spirit of staff co-operation for which I had hoped.

(iii) Objectives

The grouping in families reduces for the children the impersonality which can be engendered in a fairly large school and it provides security and warmth of affection. A weekly family meeting of children and staff is held and is the focus of the family's activities. Children's requests, planning of treats, dealing with behaviour difficulties, contributions to school activities, etc., are all discussed. In the general school life, staff encourage children to take ideas and problems to their family meetings.

A list of the family's objectives includes:-

improving children's independence in self-care and mobility;
helping with leisure time activities;
providing opportunities for children to give service to the family, the school, etc.;
organising outings and parties both for enjoyment and the accompanying social education;
maintaining good contacts with the children's homes on behalf of both the children and the school;
supervising pocket money and arranging shopping opportunities.

N.B. Much importance is laid on the training of children in self-care skills. The mother and her assistant are allowed the first period of morning school for giving tuition to individual pupils, i.e. with priority over all other time-table commitments. Really competent children qualify for a Competence Prize which involves a detailed test carried out by an independent tester, Staff Meeting approval and a formal ceremony at School Assembly. In 1969 the mothers, guided by their tutor, devised a very detailed scoring system for registering progress in the various self-care skills, a scoring system which is also a guide to training.

(iv) Autonomy

The families are allowed a considerable freedom of choice in activities for their children. Much initiative has been shown throughout the years in developing new ideas. This has been much helped by a flourishing Children's Fund which makes generous termly allocations of money to each family. Picnics and meals out are now common-place - one family has organised a week's canal barge holiday, others have been camping. These are in addition to general school-organised events. An accepted control is that approval for new family ventures is sought at Staff Meeting and notification of the timing of routine or accepted ventures is given to Staff Meeting.

(v) Liaison between the Family and Staff Meeting

This is the family mother's responsibility and she achieves this in two ways:-

(a) when the programme of case studies involves one of her children, she has to present a verbal report of the pupil's progress in self-care;

(b) she makes her contribution to the Family Business item which is a permanent item on the Staff Meeting agenda. This is mainly concerned with individual children's requests, but occasionally deals with requests or recommendations from the family as a whole.

A Typical Family

As an illustration of a family, and also to give some indication of children's multiple handicaps, I will describe a particular family as it was in 1967. I was a member of this family and my memory of it is aided by a series of photographic slides with accompanying tape-recordings which I made in the summer of that year.

Our mother had no previous experience of working with children when, in her mid-twenties, she applied for a post at Condover. The staffing position at that time was far from easy so we were pleased to give her a trial. She proved to have that combination of competence in routine duties with a warm, accepting but rational attitude to children which is so essential in a housemother.

Her staff associates were an assistant mother, the school housekeeper, the blind music master, whose wife was a voluntary family member also, and my wife who took over the family duties which I was unable to perform.

I give now some notes on the 10 children in the family. Although eight of the children appear as adults in the research section of this report where, for reasons of confidentiality, I use fictitious initials to designate individuals, I will use here the real christian names. There were two Pauls and two Keiths.

Paul (E), blind, with no intellectual handicap, had severe behaviour difficulties. He did well in braille and music. Through the concentrated efforts of a former family mother he had become independent in self-care. By his own persistent efforts he achieved a good standard of mobility. But he was easily disturbed into intense temper tantrums and completely irrational non-co-operation. Among his obsessive pre-occupations was his firm conviction that he would become the organist of Guildford Cathedral (a town with which he had no connections). He became very excited about politics, particularly nazis and fascists.

Keith (K), blind, with no intellectual handicap, was physically handicapped. For physical handicaps, I suppose, he could have been rated as (b), severe, but his obstinate determination not to give in made a rating of (a), moderate, more realistic. He was self-opinionated, bombastic, every ready to manipulate circumstances for his own advantage. Some people found these traits difficult to accept, but I found him a stimulating character. As a child, his fairly effective hands, which fiddled into everything, causing fairly frequent minor damage, got him into trouble. This habit, which eventually became less destructive and more constructive, helped Keith to become "good at being blind". His self-care became good as also his mobility about the school grounds. His unstable gait, leading to occasional falls, made independent movement in roads etc., inadvisable.

Paul (W), blind, had a moderate intellectual handicap. He was rather ineffective in handwork and practical things generally. He did not achieve the type of sensory substitution for lack of sight that might have been expected. This, however, was not due to lack of trying, and eventually he became independent in self-care and achieved a little independent mobility. Paul was a pleasant boy, anxious to co-operate and please. He was always ready to entertain, particularly with his favourite recitation of "Albert and the Lion".

Dorothy, blind, had a moderate intellectual handicap. She was pleasant, co-operative but a little lacking in self-assertion. There was a strange inconsistency in her practical abilities. She became independent in self-care,

but ineffective in most kinds of handwork. In mobility she was rather timid. She tended to rely on the help of others, which was readily available because of her pleasant temperament.

Tony, partially blind, had a moderate intellectual handicap and severe behaviour difficulties. He could switch quickly from co-operative behaviour to being completely un-co-operative. His temper outbursts were accompanied by swearing which sometimes seemed to be for effect and sometimes aimed to hurt the feelings of staff and pupils. He was interested in pets but could be neglectful of them and at times positively cruel. He was independent in self-care and unrestrained in mobility, in that his behaviour in public was incalculable and he was likely to put himself in danger in traffic.

Tim, partially blind, had a moderate intellectual handicap and a very severe physical handicap. He was mainly confined to a wheel chair though he could transfer himself from it to bed or an ordinary chair. He could manage to pull himself along, holding a rail, for two or three yards. His hands were severely affected though he could manage to carry out some self-care activities and a few simple repetitive manual operations. Two of Tim's positive attributes were a readiness to try and a certain dry, quizzical, leg-pulling humour.

Linda, partially blind, had a severe intellectual handicap (B), a very severe physical handicap, a very severe behaviour handicap, fairly frequent petit mal attacks and a fairly severe speech defect. Poor girl! Her behaviour handicaps included obstinate lack of co-operation, temper tantrums, and unexplained outbursts of grief. Although one felt sorry for Linda, it was difficult to like her, except in comparatively rare periods when she made friendly overtures.

Mike, partially blind, had a severe intellectual handicap and a moderate behaviour difficulty. The behaviour problem was not very marked, being mainly a matter of immaturity which manifested itself as a "nuzzling" for affection, bouts of obstinacy and outbursts of childish temper. Although he had no specific physical handicap, his muscular control, particularly in his hands, hindered progress with self-care skills.

Robert, partially sighted, had a very severe intellectual handicap and moderate behaviour difficulties. The two latter handicaps were quite marked in 1967. Gradually the intellectual handicap decreased to severe instead of very severe. His unusual behaviour which showed itself as a withdrawal from personal contact also improved and he began to show and accept affection. Robert became independent in self-care but remained timid in mobility.

Keith (S), partially blind, had a very severe intellectual handicap and a moderate behaviour handicap. This behaviour pattern was one of withdrawal. It was quite difficult to establish any rapport with Keith who had irrational conversational obsessions, his main one being with "tunnels". His train journey home took him through the Severn Tunnel and this appeared the only rational explanation of his obsession. He conformed in family and in school in a negative fashion. Keith achieved moderate success with self-care but very little success in other manual skills.

Summary

These 10 children and their multiple handicaps form a representative sample of the school population. The only type of handicap missing is hearing loss (d) which, in any case, is a defect which only occurs comparatively rarely.

Family Business at Staff Meeting

I have checked through Staff Meeting minutes for 1967 and have found that, for this selected family, there were:-

Ten items of general family business: five requests for use of the school 'bus, one for a seaside trip, one for Christmas shopping and three for evening meals out; an appeal for some regulations to be made for pupils pushing physically handicapped children in wheel chairs; an application for reserved use of two rooms for a family party; a suggestion for improvement in sandwich fillings; a recommendation for a letter of thanks to Belle Vue Zoo staff for a series of school visits; a suggestion that a newly donated cup should be awarded as a prize for an archery competition.

Forty-nine items on behalf of individuals. These included routine requests for more mobility training, later bed-times, school purchase of gramophone records and for improvement in food. The most ambitious request was made by Keith (K) for the purchase of a portable tape-recorder for use by a group of physically handicapped boys who were producing a taped weekly newspaper based on a classroom recorder. An interesting request was from Linda who asked to watch the T.V. Cross Quiz during tea-time and involved the saving of her tea.

All requests were granted except that Tim had to be told that his request for training in independent use of the school record player must be refused regretfully because the manipulation was too difficult for him.

Life in the Family Flats

The number of children has been reduced to eight, but the principle of mixing sex, age, and handicaps remains as before. Some advantages have been gained from life in the flats compared with the more large-scale communal living which occured before 1969 and they are listed here:-

With the majority of cooking, eating, and associated chores taking place in the family group, there are many more duties with which children can help. Education in some aspects of homecraft occurs naturally and frequently.

Food supplies for several days are delivered from a central store. Type of food and quantities are controlled, but mothers, their staff, and children can decide how and when the food is used.

Timetables for the late afternoon and evening, times of tea, evening snack, bed-time, bathing, etc., can be adjusted to family and individuals' wishes. Times of school-arranged leisure activities and clubs have to be borne in mind but there is a considerable amount of free family choice.

For the children there is the definite feeling of living "at home" and of "going out" to school and other activities. Exchange of visits between children in different flats is a pleasant activity. Parents, official and unofficial visitors can easily, and with good social benefits, be absorbed into the life of the flats.

Summing up:- all the objectives of the Family System, which remain as important as they ever were, can now be attained much more easily.

Child Care Staff Training Course

During the 1960's it became increasingly difficult to recruit suitable Child Care Staff, and trained staff were unobtainable. The R.N.I.B. approved the formation of Condover's own In-Service Training Scheme. A senior family mother attended an Advanced One Year Course and, on successful completion of the course, she was appointed as Tutor to the In-Service Scheme which she was to initiate and run. This appointment took place in 1968, at a very opportune time, since the Tutor was able to co-ordinate child care staff ideas and formulate plans for the functioning of the flats which were then under construction.

The In-Service Scheme has three levels of instruction, two compulsory in that newly appointed staff agree to undertake training, and the third is voluntary. The Basic Course is for newly appointed junior staff, usually aged 16-17, who are employed as classroom aides and who have some residential duties also. Progress in practical and theoretical work is dealt with on a continuing assessment basis, but the course ends with a formal written test and an interview with a small panel of external assessors. Success in this course is a qualification for a post as Assistant Housemother and leads to the Intermediate Course. This is similar in content to the Basic Course but at a more advanced level. Success at Intermediate level is a qualification for appointment as Family Mother. The Senior Course is voluntary and reserved for staff already working as Family Mothers. The main features of this course are an assessment of practical work by external examiners and a detailed special study. I must emphasise that the training scheme is not nationally recognised, but is organised and approved by the R.N.I.B. which grants increases of salary to staff who successfully complete each of the courses.

Staff Meetings

It was natural that, during the school's first term it was necessary to hold frequent staff meetings to decide the practical details of the organisation of the new school. When, in the second term, the number of children was doubled, with consequent extension of the family system and the employment of new staff, the continuance of staff meetings seemed a logical development. Within a year the number of children had increased to 72, at which number it has remained except for the addition of the deaf-blind department. It became increasingly difficult to arrange informal staff meetings and quite soon the tradition of a weekly staff meeting became established.

Since I felt that the staff meeting should be the central feature of the school organisation, it seemed necessary to plan it firmly into the school timetable. This implied that it should take place during the day and not be fitted into an odd hour in the evening. Staff should consider attendance as part of their working hours. The problem of what to do with the children while two-hour staff meetings were being held was solved by my wife undertaking a semi-organised leisure programme for the children in which she received help from junior staff and from occasional voluntary helpers. Arrangements were made for a senior member of staff to discuss with the junior staff important features of the staff meeting business at the end of the meeting.

In the early days of the school I had not fully realised how important the democratically based staff meeting would become as the accepted policy-making body of the school. Its discussions of child studies, school procedures, and attitudes to children had become an important informal training experience, particularly for new staff. From 1949 onwards minutes of staff meetings were kept and there developed a tacitly agreed procedure. I hope, though, that we

managed to maintain a lively air of informality at the meetings so that younger members of staff were not overawed when their turn to contribute arose. The agenda included, and still includes, family business, child study, reports and decisions on children presented for a residential assessment period for possible admission, news, development, etc. Provided prior notice was given any member of staff might raise any topic. Although no children attended staff meetings, they were involved in its deliberations by the Family Business procedure.

School Assembly

Although no children attend Staff Meetings, they are involved, to some extent, in its deliberations by the family procedure which I have described. In addition there is the School Assembly, attended by all children and staff, which is held on the morning following Staff Meeting. No information is leaked to children before Assembly which is a very important weekly event for them when the Headmaster presents his "Report from Staff Meeting". The pupils learn what decisions have been taken about family and individual requests, they are kept informed of general items of school news, developments, etc., and occasionally they can vote on certain issues - in practice these votes are usually concerning food.

Sunday Service

Throughout my period at Condover, I held a Sunday Evening Service. In a way this was a strange activity for me since I hold no formal religious convictions. Yet I felt I had a duty to the children and their parents to present some form of Christianity which would be understandable to the children and not offend my own feelings of honest lack of convictions. Hymns, Bible readings and simple prayers formed the framework for two practical exercises: (a) I gave an "address" of an "ethical" nature mainly devoted to school and personal behaviour, often elaborating on items discussed in Staff Meeting and announced in Assembly and (b) I read the School Diary giving advance information of events, visitors, etc.

The School Programme

So far, in this chapter, I have been discussing the community organisation, emphasising the importance of social education and the integration of all staff in creating a life for the children which is educational in the broadest sense.

I turn now to the teachers and the programmes which they provide during school hours. Most of our teachers had little experience with handicapped children before they came to Condover and had to adapt themselves to different objectives and methods. Children's progress measured against that of normal children is slow and ultimate attainments are limited. Measured against their handicaps, however, slow and limited progress can be a great achievement. It is axiomatic that all education should be based on each individual child's abilities, aptitudes and needs and this is absolutely vital in a school like Condover. In the discussion which follows I am referring to the period up to 1971 when I retired.

Since it is impossible to provide one teacher per child, some grouping of children is necessary and throughout the years we have experimented with various types of class structure. There has always been one permanent feature - each full-time teacher, apart from the music specialist, has had his or her own class for part of the week. It became traditional to call this class a Study Group which is a shortening of the original term of Environmental Study Group.

In the early days we tried to run the four morning periods without a fixed class pattern. The teachers acted as specialists and we tried to form fairly homogeneous groups of children for each subject. After each period, regrouping of children for the next set of subjects would take place, since for instance a group of "advanced" braille learners were not a homogeneous group for physical education. We found this impossible to run properly. Later we tried a modification of this programme by dividing the children into four departments, one of three classes for physically handicapped children labelled D Department and the three others, A, B, and C, of two classes each, were graded on a basis of age and ability, with the A department having the older more capable children where capability was in terms of ability to do effective or fairly effective work on leaving school.

Although the department idea has, to some extent, disappeared, the D department has remained in name and constitution. The three teachers have devised a pattern of education which, although three separate classrooms are used, has some of the features of open-plan education. The A department remains in function if not in name though it caters for the older children regardless of ability.

In 1956 a general inspection by the Department of Education and Science took place and although the report was generally favourable, a criticism was made that there was not enough correlation and continuity between the programmes of the Study Groups. This led us to devise a programme of six environmental study projects which is repeated every two years with the important proviso that each teacher would interpret the subject in the light of the capabilities of his pupils, both as a group and as individuals. In study groups and in specialist subjects this principal of adjustment to individuals has replaced the idea of homogeneity of the group. The matter of individual attention has been much helped by the fact that each teacher has the help of a classroom aide, a young lady who also has a programme of residential duties.

I will now outline some of the features of the school programme.

Environmental Study

The six projects referred to above are:-
living things, very much based on simple human biology;
food;
transport;
communication, i.e. post, telephone, newspapers, etc.;
the house and its equipment;
other people's houses, buildings, etc.

The emphasis is on knowing yourself and your immediate environment before studying the wider environment. Simple geography, social studies, and science should be included where possible. Educational trips are encouraged and school transport is available according to a rota.

Literacy

Programmes of reading and writing in braille and "sighted" are provided. Inability to learn to read and write is not equated with educational failure. Some of the teaching is remedial and some, especially in braille where use of the writing machine, has an aspect of occupational therapy. Some of the more intelligent pupils become very efficient users of braille.

Handwork and Practical Work

There are specialist teachers full-time for Homecraft (for boys and girls) and Varied Craft-work and several other teachers specialise in some form of practical work. Pottery, "artistic handwork", repetitive exercises and some simple machinery, are provided, though no pupil is able to attend all the handwork classes. A feature is a complete day of work for pupils nearing school-leaving age.

Music

The school always has an enthusiastic choir which gives enjoyable concerts. The learning of new tunes and words is achieved with surprising ease. Flagging interest of the boys was revived by the formation of a four-part choir where, again, the facility with which part-songs were learned was really surprising. Undoubtedly there is considerable musical talent among multi-handicapped blind people, with the possibility of its development towards the more popular forms of music and more portable instruments than piano. The school had a good record of success of its pupils in piano playing, but apart from voluntary teaching of brass instruments by a teacher skilled in this form of music, we could offer no systematic teaching except of the piano in my days. I believe a new music master is now offering a more catholic range of music teaching.

Mathematics

This is a grandiose title for the simple arithmetic which formed the complete mathematics programme at Condover. The teaching of this subject to multi-handicapped blind children presents considerable problems. Only a few pupils are able to do written work. Only approximately a quarter of the children can learn to use symbols in braille or print to represent numbers. Number concept development for most children is very retarded. Teachers therefore concentrate mainly on practical work in counting, adding, and subtracting, plus experience with weights and measures, with considerable emphasis on money. For at least half of the pupils an understanding of the value of money and its purchasing power remains almost nil. I devised a pocket-money scheme which was accepted by the staff. The scheme had five stages and pupils were supposed to have always in their possession some money which, hopefully, they could count and which would lead to the next stage. The lowest grade was just a few pence, systematically replenished, and in the next grades other coins were added with consequent increases in the total of money held. The pupils in the highest grade were encouraged to think of termly totals of pocket money of three or four pounds. Pupils were to have opportunities of buying things at a price level commensurate with their pocket money grade. If children in the lower grades wished to buy more costly things, they were supplied with the requisite money, or were to be encouraged to save. When I retired, decimal money was just coming into use and there was a hope that this system would be more simple in use and a benefit to the Condover Mathematics scheme!

Mobility

The formal and carefully planned teaching of mobility is integrated into the leisure-time programme of privileges which began in 1950 when traffic problems were less intense than they are now. In 1967 a staff sub-committee up-dated the system of training which takes place on Monday mornings in the school grounds, the village, the nearby roads and in Shrewsbury. Pupils use a white stick, but not the long cane. Orientation and road-crossing techniques are taught as well as the position of the safest place for crossing roads, use of curbs, use of sound and obstacle detection.

The "Privileges" system is based on training and test followed by the privelege of individual unsupervised travel, in three stages in the village and two longer stages.

The first stage is for Shop Privelege. This involves walking along paths in the school grounds for about 250 yards, crossing a public road and going a further 50 yards to one of the village shops. The second stage means walking a further 200 yards, with another road crossing to the post office, which is also a shop. Independent privilege is easily gained by pupils with some sight and many blind children achieve these two first stages. The third stage means travelling another 300 yards to a third shop and this involves a rather difficult crossing. A few blind children train for and gain this third privilege which is a fairly difficult journey for them.

The fourth stage known as Short Distance is concerned with journeys to neighbouring villages, with a maximum round trip of about seven miles. For safety and convenience pupils are required to travel in two's and a tradition has been built up of pupils training each other. Someone who has learned the routes to about 10 different places and has passed the test, takes on the training of other pupils, who, when trained, takes on the training of a new trainee. This process has been carried out for 20 years at week-ends as afternoon walks. It is much helped by shop-keepers and householders in the villages who sign a card brought by the pupil and indicate the time of arrival. This device has been given the name "autographs". Many staff who book out pairs of children for autographs at week-ends have never visited the children's destinations. The majority of children on this fourth stage have some sight but about one in four is blind and a few of these eventually take over the training of a "sighted" friend. At least a dozen pupils are involved in this week-end activity which is a remarkable example of a process becoming a tradition.

The fifth stage known as Long Distance is very much a staff-controlled training mobility exercise in Shrewsbury for pupils nearing school-leaving age. The autograph system is very useful here after pupils have learned the essential ways about town under staff surveillance and are ready to move beyond direct supervision. There are, usually, only two or three pupils who hold the final Long Distance Privilege and are allowed to go alone to town by 'bus - a distance of five miles - but they are usually "sighted".

Parents are consulted when their children reach an important stage of development in the scheme and their consent needed before more complicated training takes place. When one remembers that the children are visually handicapped with other handicaps and that the training scheme was begun in 1950, one realises what a remarkable activity it is.

"Adventurous" Pursuits

Mobility training is an example of a school based training which becomes part of the community life. There are other examples of this type also. Camping is taught 'in class'; individual children camp out alone in the school grounds occasionally at night. School and family camping expeditions take place from time to time. Canoeing and boating of a simple nature are taught. Horse-riding, which began as an activity, arranged for physically handicapped children only, at a small riding school, is now part of the school and leisure programme since the school now owns two ponies. Archery, which also began as a reserved occupation for the physically handicapped, is now practised by other children.

Swimming

I thought of listing swimming under Adventurous Pursuits, but it is so much a part of the school programme and is taught to almost every pupil, that such a classification is not justified. At least 80 per cent of the children learn to swim and it is particularly rewarding to see seriously physically-handicapped children swimming with confidence. Many children passed the Swimming Awards for Handicapped People of the Amateur Swimming Association. About 25 have obtained the Association's Bronze Award for Personal Survival and 10 have gained the Silver Award - including three seriously physically-handicapped pupils, two of whom are totally blind.

The "Twenty-Minute" Period

This is an event which involves all staff and takes place on two days per week during the first 20 minutes of the school programme. It evolved from the staff feeling that children with behaviour difficulties might profit from frequent relaxed personal contact with the same person, someone who felt sympathetic to the child concerned. This basis to the scheme remains although it was soon extended to include every available member of staff taking one or two children for these friendly periods of conversation or activity. The only exception is that, from time to time during the functioning of the 20 minute period scheme, to ensure personal attention for the majority of the children, groups of children meet for activities of common interest, the most important of which merits a paragraph of its own:-

The "Reina del Mar" Group

The Reina del Mar is the school's adopted ship. The Children's Fund has benefitted greatly from frequent generous contributions from the ship's crew, mainly as the outcome of the children's parties organised on the ship, which is a well-known cruise vessel. Liaison between the school and ship is achieved by the Reina del Mar Group which is directed by a teacher and has a membership of one member elected by each family. This is the most long-lasting sub-committee of children (at least 10 years) others having been formed occasionaly for other projects.

Contacts outside School

Many of the educational and social activities which I have described had, as primary or secondary aims, the reduction of the isolation which arises from the setting up of a specialised residential community like Condover. I will now describe ways in which, to some extent, the isolation was overcome.

Parents

The children come from many parts of the country. At any given time the situation would be something like this: the homes of about half a dozen children would be less than 50 miles from school; a similarly small number of homes would be more than 250 miles away; the average distance between school and home being of the order of 150 miles. Since the school should serve parents as part of its duties, this distance is a considerable obstacle. Letter-writing, sending of parcels, and telephone conversations which are organised at the school end by the school family help considerably. Contact with the Principal is only made if any difficulties arise or important decisions have to be made. Parents are welcome as visitors at any time and residential accommodation is usually available for the first two or three visits. Frequent parent visitors are asked to arrange their own local accommodation. Many parents make day visits. After free provision

of meals for the first few visits, parents are asked to pay a reasonably small sum for meals taken at school.

Early in the school life the staff felt that some more formal organisation was needed, especially to establish contacts with parents we rarely or never saw. Therefore the series of Parents' Conferences was begun and this important development warrants a separate section.

Parents' Conferences

At first, these conferences were arranged annually but later, when parent-school communication had been improved on a more informal level, the meetings were arranged once every two years.

The organisation of the conference is as follows. It is held during a week-end which precedes the opening of a new term. Two pupils from each school family arrive on the Friday afternoon accompanied by their parents and all stay for the week-end in the school where all the staff are in attendance. The parents leave on Sunday evening or Monday morning. The pupils who have not attended the conference arrive on the Monday and the new term gets under way.

Conferences proceedings are arranged fairly informally. Two, sometimes three, general meetings of the whole group are held but the main activities are carried out at the more intimate "en famille" level. Parents get to know staff directly involved with their children in the school family and in the classes. One feature is that the teachers run a modified school session during which the Family Mothers take the parents on a tour of the school. The parents learn much about Condover's ideals and practices during the week-end. I used to hold a private interview with each set of parents.

There are three extra points I would like to make:-

Equally as important as the contacts between staff and parents are the contacts between parents themselves, with the opportunities for sharing ideas and problems.

The conference is an educational experience for the staff. Meeting the parents has a boosting effect on morale and motivation.

In carrying out my research survey and visiting parents many years after their attendance at a conference, I realised what a helpful and lasting effect this event had produced.

The Village

Although there are no formal arrangements for contacts between school and village, these are unnecessary. The school, its children, and staff, have been accepted as part of the village life. The children move freely around the village streets; they are welcome in the shops; those who wish to do so attend the village Church; when there was a village youth club, half a dozen of our children attended it. Quite a number of villagers are employed at the school and a pleasant feature of this has been the friendly, helpful, direct personal contact which these workers have established with the children.

Community Service Volunteers

Here I include members of the official organisation and some other helpers who are not connected with the C.S.V. Nearly all the helpers have been in the age-range of about 14-18. They help with evening duties or with Sunday afternoon walks, particularly with physically handicapped pupils. The actual duties which they perform are very helpful but even more welcome have been the friendly individual contacts with the pupils.

The British Railways Condover Hall Adoption Society

This society was founded in 1958 and is still flourishing. When the society sought my advice at the time of its founding I stressed that personal service would be more important than material and financial aid. In practice the members of the society have combined both material and personal service. About 20 pupils spend several hours, including tea, at individual railwaymen's homes one Saturday per month. When the Society provide their annual outgoings (sometimes there are two), and make their contribution to events held at school, the members always attend in force to be with the children as their "Railway Friends" and to help with the festivities. The active members are men and women who are present or past railway workers - drivers, clerks, guards, etc. They have always had personal support and help from senior officials of the Railway which has facilitated the running of the Society and, also, financial help from railway employees in many parts of the country which has enabled the Society to be so very generous to the school and its children.

Conclusion

I hope I have given a fairly clear idea of the ideals and practices of Condover. May I remind you that the school deals with multi-handicapped blind children, the majority of whom are very seriously handicapped. Although many of the activities I have described are suitable for the more intelligent and the more able pupils, we tried to ensure that even the most handicapped could take part in the life of their school.

Aims of Present Investigation

Two short postal surveys of the placement of former Condover pupils took place many years ago, the later one in 1961. In 1967-68, a successful pilot study of ex-pupils was undertaken by Miss Joan Francis, a former member of Condover staff. This pilot study was prompted by the School's Governors who were very interested in a full research survey being carried out. Lack of finance led to the indefinite postponement of the project until quite unexpectedly the possibility arose of a research survey being carried out under the aegis of the Research Centre for the Education of the Visually Handicapped at Birmingham University. I was appointed as Senior Research Associate and I began the research in 1971 when I retired from Condover two or three years before I need have done.

Suddenly the responsibility was mine and I had to consider the methods and objectives of the research.

The principal feature of the method seemed obvious: I should visit all the former pupils and find out what they were doing at first hand. I had in mind the following objectives:-

the description and evaluation of any facilities being used by ex-pupils;
an attempt to estimate how far school activities and training had proved to be helpful;
the feed-back of information and ideas to school which might lead to the modification of the school's educational programmes or the confirmation of the values of existing schemes and methods;
and on a wider basis I was interested in the needs of multi-handicapped blind people generally and I wanted to assess:-

the extent to which such people are, or could be, integrated into the facilities for the blind or for other handicapped people;
the need for improvement of services.

I was aware before my investigation began that there were conflicting ideas about how revisions taking place in Social Services are affecting blind people and I wanted to formulate some comments and suggestions on these topics as objectively as possible.

The research was concerned with all the pupils who attended Condover from its opening in 1948 and who had left school before the end of 1970. This total is 393, but 50 have died and 29 were untraced, so that the research survey deals with 314 ex-pupils. The handicaps of the 314 people, 190 of whom are men and 124 are women, are tabulated below:

Visual Handicaps		Intellectual Handicaps		Physical Handicaps		Behaviour Handicaps		Deafness		Epilepsy
P.S.	75	Nil	61	Nil	220	Nil	207	Nil	270	65
P.B.	102	A	129	(a)	31	m	68	d	20	
B.	137	B	82	b	26	M	39	D/B	24	
		C	42	c	27					

The scoring scheme for the handicaps is:-

Vision: PS - partially sighted; PB - partially blind; B - blind.

Intellectual Handicap: Nil - average range; A - moderate; B - severe; C - very severe.

Physical Handicap: a - moderate; b - severe - c - very severe.

Behaviour Handicap:m - fairly severe; M - very severe.

Deafness: d - speech communication possible, educated with hearing children; D/B - educated in special department for deaf/blind children.

Epilepsy: active epilepsy or drug treatment continuing.

Discharged: before school leaving age.

Promoted: before school leaving age.

Occupation Estimate: i - open employment; ii - sheltered employment; iii - useful in occupation centre; iv - diversionary only; v - incapable.

A copy of this scoring scheme is printed on the bookmarker. Chapter 2 is a full discussion of the handicaps and their severity. Occupation estimates are discussed in Chapter 5, pages 70-71 and page 73.

CHAPTER 2

VISUAL AND OTHER HANDICAPS

All the multi-handicapped people who are the subjects of this research have a visual defect, but before dealing with this topic, it is important to mention the following relevant points. Although a few specialised facilities for multi-handicapped blind adults exist they have few or no vacancies for new admissions. There is no likelihood of the opening in the near future of new specialised centres, but there is an increasing amount of integration of multi-handicapped blind people within facilities for other severely handicapped people. Many ex-pupils of Condover are now placed in hospitals, centres, hostels, etc., among seeing handicapped people. Staff undertaking the care of people with little or no sight under these circumstances have rarely had either training or experience with such people and naturally they sometimes express their feelings of inadequacy and often they hope for aid from a 'specialist' who has been trained to work with visually handicapped people. Such specialist help is rarely available even at the level of occasional advice or support and certainly not as a continuing service but fortunately most staff are prepared to continue working with the visually handicapped and this hopeful development for their well-being is being maintained.

It seems advisable that this chapter, which is concerned with types and severities of handicaps, should be divided into two sections:-

Section A. Vision and Visual Handicaps. Although this is connected with my research survey, it is mainly a kind of "everyman's introduction" to vision and the designation of visual handicaps. I describe the ophthalmological procedures of assessing vision and I discuss the implications of severe visual impairment for the development of such skills as self-care, mobility, independence, home management etc. This discussion is based on my own experience of working with normal blind people and I hope the section will be of practical help to those people now caring for visually handicapped people in institutions primarily catering for the sighted. In the discussions I arrive at the classification of visual handicaps which are relevant to my research survey.

Section B, entitled "Other Handicaps" is specifically geared to the non-visual handicaps found among the subjects of the enquiry. I make no attempt to describe how the visual handicaps affect the additional handicaps.

SECTION A: VISUAL HANDICAPS

The phrase "The Visually Handicapped" is now being used quite widely, and officially, to designate the considerable variation of poor vision from total blindness on the one hand to good partial sight on the other.

It must be made clear that the terms "visual handicap" and "visually handicapped people" are not kindly-meant circumlocutions to avoid the use of the words "blindness" and "blind people". It is true that many seeing people who have little or no contact with blindness react to a blind person with a mixture of emotion and embarrassment which can arouse in the blind person a mixture of amusement and embarrassment - and, sometimes, emotion. Two well-known facets of a seeing person's reaction to blindness - and the reaction is to the blindness rather than to the blind person - are (i) a tendency to address remarks or questions to a blind person's companion rather than direct to the blind person and (ii) a tendency to avoid any direct reference to blindness in conversation with a blind person.

Let us consider the confusing situation in which a person with no previous experience with blind people has a first contact with a person reputed to be blind. For example, one hears of a man who reads braille and who also rides a bicycle on quiet stretches of road. The feeling of wonder that a blind man can perform such a marvellous feat diminishes when it is discovered that, when riding the bicycle, he is using effectively his small amount of residual vision. Similarly, visitors to a school for blind children can be amazed at the speed and accuracy of the children's movement around the school buildings and grounds. Later, they realise that many of the children have some useful vision.

Such introductory experiences to "the world of the blind" understandably lead to lack of appreciation of two important facts:-

(a) Some totally blind people, who have to learn to live effectively with no vision at all, develop some really remarkable special skills.

(b) Many people classified as blind, who have a little vision, are faced with problems of personal adjustment probably equally as difficult to resolve as the adjustment problems of the totally blind.

Legal Definitions

There are two broad categories of visually handicapped people, the legally blind and the partially sighted. In both categories there are different definitions for children and adults though there are no fundamental contradictions.

The 1944 Education Act defines blind pupils as those "having no sight, or whose sight is, or is likely to become so defective that they require education not involving the use of sight". A regulation of 1945 defined the legal meaning of partial sight and was slightly modified by a Regulation of 1959. This definition, which is the currently accepted one, reads "Partially sighted pupils are those children who, by reason of defective vision, cannot follow the normal regime of ordinary schools without detriment to their sight or to their educational development, but can be educated by special methods involving use of sight." The Vernon Committee (Dept. of Educ. and Science Report, 1972) considers that for children a new method of notification and assessment is urgently needed.

As regards adults, although nearly all the provisions of the Blind Persons Act of 1938 have been superseded by the National Assistance Act of 1948, the legal definition of a blind person contained in the 1938 Act is still valid, viz. "so blind as to be unable to perform any work for which eyesight is essential". There is no statutory definition of partial sight in the 1948 Act but the then Ministry of Health advised that a person not blind within the meaning of the Act but who is, nevertheless, "substantially and permanently handicapped by congenitally defective vision or where such vision has been acquired through illness or injury", can be registered as partially sighted.

Though registration as "blind" or "partially sighted" is not compulsory, most people with defective vision do apply for it since they then have access to special educational, welfare, and other services. The statutory medico/legal requirements involve completion of Form B.D.8 by a qualified Consultant Ophthalmic Surgeon. Entitled "Examination for admission to the register of blind persons or to the register of partially sighted persons", the Form has four sections (Examination of the Eye, Clinical Assessment, Certificate of Registration, Recommendations) and is used for children and adults.

Registration

The ophthalmologist's examination of a person with defective vision proceeds rather like this:-

The consultant expects to be provided with all available medical information concerning the circumstances of the actual eye trouble and he hopes to learn of any family history of defective vision. He makes a detailed examination of the eyes and diagnoses the cause of the defective vision, naming the actual disease or pathological condition. If medical or operational treatment is required he recommends the appropriate action to be taken and defers further consideration of registration until the treatment has been completed. Then the consultant makes a prognosis concerning the future of the eye condition. The procedures thus far are of specialist medical interest but are of minor importance to those people who will help in the education, training, or welfare of a visually handicapped person. It is interesting for these people, who will become professionally involved with the handicapped person, to know what the eye condition is, but it is vitally important that they should know about two things:-

(a) Is there any possibility of any change in vision, and, in particular, is it necessary to take any precautions to prevent any deterioration in vision? (It should be noted that this possibility of deterioration is not common, being of the order of something less than 5 per cent among registered blind persons below the age of 65).

(b) If a person is not totally blind, how effective is his residual vision? It is most important to bear in mind that, apart from the minority of people referred to in the previous paragraph, no harm is caused to a person's defective vision by the use of this vision. In fact its use may help to prevent deterioration or it may help a visually handicapped person to make more effective use of his defective vision.

Visual Acuity

For the measurement of any residual vision, the patient's co-operation in reporting reliably on what he sees is essential. With a very young child or with a person unable to co-operate in a careful examination through temperamental, intellectual, or physical handicaps, the accurate diagnosis of visual acuity is difficult. The ophthalmologist has to rely on what he has learned from his examination of the eye, on his observations of the behaviour of the patient, plus any reliable, reported observations by other people who know the patient.

With a co-operating person - the great majority - the measurement of visual acuity passes through the following stages. There may be minor variations in the ophthalmic surgeon's procedures, but the basic visual measures are:-

(a) Total Blindness This is usually easy to establish. There may be no eyes. Eyes, if present, do not react to light, i.e. the pupils do not contract when a bright light is shone on the eyes. Sometimes this nil visual acuity is recorded as "No Perception of Light" abbreviated to "No P.L.". Only approximately 10 per cent of all registered blind people are totally blind.

(b) Perception of Light Only A person with only this very small amount of vision is simply aware of the difference between light and darkness. Such vision is roughly comparable to that awareness of light which a seeing person has when his eyes are closed. The usual abbreviation for the description of this minimal vision is P.L.

(c) Hand Movements The person being tested is aware of hand movements being made at about six inches from his eyes by the examining consultant, who is careful to make the movements in such a way that there are no additional clues given by draughts or noises of movement. A seeing person looking, with eyes closed, towards a reasonably bright light is aware of such hand movements when they pass

before the light. Visual acuity at this low level is very vague. People with sight at its upper range can give a rough indication of the position of a gently moving hand about two feet from the eyes, the hand not passing between the eyes and a bright light. They may have a visual awareness of the presence of a nearby large object though they do not recognise its size and nature. The obvious abbreviation of H.M. is used to designate this level of visual acuity.

(d) Counting Fingers The next stage is quite a large step forward in visual acuity. It involves the patient's ability to count fingers held at varying distances from his eyes by the consultant. To the obvious abbreviation of C.F. is added the maximum distance at which the patient successfully counts the fingers, e.g. C.F. 6" or C.F. 2' or C.F. 1 metre.

(e) The Snellen Test A person being tested, who does well in the counting fingers test, proceeds to the use of the Snellen Test Card, which is the usual card of letters of various sizes seen in surgeries and hospitals. The tests for the four previous grades of visual acuity are somewhat vague or approximate and are necessarily so because of the very low levels of vision concerned. With the use of the Snellen Test the measurements become much more precise and scientific. The sizes of the letters and their component lines and curves are of definite dimensions depending on the angles they subtend at the eye of the person being tested. The test card is much used for the testing of people with normal vision or with slightly defective vision when the question of the provision of spectacles is being considered. Since the vision of people with normal sight deteriorates with age, and spectacles are useful for them from the age of about 45, many people have the experience of being tested with the Snellen Card.

The lines of letters of the card correspond with the distances at which the letters can just be deciphered by people with normal vision. The top line has one large letter which is just read by someone with normal vision placed at 60 metres from the card. The other lines of letters are of gradually decreasing size indicating distances of reading with normal vision at 36m, 24m, 18m, 9m, and 6m from the card. Some charts include lines of even smaller letters which can be deciphered by a person with normal vision at 5m and 4m.

Usually the person being tested is placed at 6 metres from the card and it is decided which is the line of smallest letters which he can just read and the vision is recorded as, for example, 6/60, 6/18, etc. This means that he sees at six metres what a normally seeing person sees at 60 metres or at 18 metres, etc. When someone is being "measured for spectacles" he wears a special frame into which lenses are dropped until the one is found with which he can read the line of smallest letters possible for him. This method of testing is used throughout the whole range of vision from people with quite severe visual handicap, where spectacles may help a little, to people with near normal vision which can be improved with glasses.

Let us now concentrate on the special case of people with severe visual handicap being considered for registration as blind or partially sighted and the relevance of the Snellen Test. The very important point should first be made that, when decisions are made about registration, it is the corrected vision, after the most effective improvement with the aid of spectacles has been made, which is taken into consideration — not the natural, unaided visual acuity. Neither the statutory definition of blindness nor the recommended definition of partial sight contains any reference to specific visual acuity. This was a wise decision since there are other factors than visual acuity which should be taken into account when a decision about registration is taken. A brief reference to these other factors will be made below. There are, however, some useful approximate guide lines concerning visual acuity which ophthalmologists use and which are easy for the layman to understand.

Two borderline visual acuity measurements are particularly important. These concern the ability of people to read the top letter of the chart from a distance of six metres, i.e. a visual acuity of 6/60. People failing in this test then try to read the same letter from a distance of only three metres i.e. a visual acuity of 3/60. This leads to two inter-linked decisions:-

People with a visual acuity below 3/60 should be registered as blind.

and People with a visual acuity of 6/60 or better should not be registered as blind.

This leaves two groups of people for whom special ophthalmic factors must be considered. These factors, which emphasise the important role played by the consultant ophthalmologist, include the field of vision, the type of eye defect or disease, and the prognosis with regard to visual acuity. The two groups of whom these additional factors need to be considered are:-

(a) Some people with visual acuity in the "no man's land" between 3/60 and 6/60 may be registered as blind, others as partially sighted according to the severity of the ophthalmic condition.

(b) People with a visual acuity of 6/60 or more may be considered for registration as partially sighted. The upper limit for registration is often 6/36, but this is sometimes extended to 6/24 or even 6/18 according to the severity of the ophthalmic condition.

These matters of visual acuity are not mentioned in the actual certificate for registration which is part of the B.D.8 and needs the consultant's signature after he has answered Yes or No to four important questions. These questions concern all people, no distinction being drawn between children and adults, and they are:-

FOR BLINDNESS Do you consider the person "so blind as to be unable to perform any work for which eyesight is essential"?

FOR PARTIAL SIGHT If the person is not at present "so blind as to be unable to perform any work for which eyesight is essential" do you consider that the person is substantially and permanently handicapped by defective vision caused by congenital defect, or illness, or injury?

FOR A PERSON CERTIFIED AS PARTIALLY SIGHTED (a) Is he likely to become "so blind as to be unable to perform any work for which eyesight is essential"? (b) Is blindness likely to occur so soon, or is the nature of the visual defect such, that he would benefit from training for employment or other services appropriate to blind people?

The Vernon Committee considers that the form B.D.8 is not suitable for children and recommends that a new form should be devised for children with the suggested title of Notification of Visual Handicap. The B.D.8 asks for no information on near vision, and does not give sufficient attention to the presence of other physiological or neurological defects which may co-exist with the visual handicap. All these factors have educational implications and the new Notification Form would give information on these important matters. Since it is often difficult to assess young children's vision accurately and, in any case, changes in vision or discoveries about its use sometimes occur during school life, it is recommended that all visually handicapped children should be re-assessed frequently.

The very important decision has to be taken about children with a small amount of vision as to whether they should use braille or inkprint. Decisions should be taken on a panel basis, in which, when appropriate, the consultant ophthalmologist would be joined by another consultant from another branch of medicine, an educational psychologist, a teacher, a social worker, or the family doctor. There may be no need for the complete panel to meet but individuals should be able to be called upon when necessary.

It should be pointed out that, although there is no mention of close vision on the B.D.8, the consultant ophthalmologist normally carries out a procedure of assessment of a person's ability to read ink-print. This examination is based on the recognition of print of standard sizes, the distances from eye to print at which clear focussing takes place and the improvement which may result from the use of spectacles, contact lenses or even, in special cases, of low visual aids. In fact the consultant is asked to give recommendations on these matters on the present B.D.8, so it is, perhaps, incorrect to say that the present registration procedure gives no information on near vision. Nevertheless, with very young children and with school children more detailed information is certainly needed.

I end this section with the following additional observations:-

(a) The Vernon Committee's Recommendations about improvements in the assessment of visual handicaps in children have already been considered by the Department of Education and Science, the Department of Health and Social Security, and other interested people, including consultant ophthalmologists. A new form largely in line with the Vernon Committee's suggestions is likely to be produced soon.

(b) It is likely that, if the new Notification Form were approved, it would be agreed that the present B.D.8 with some slight modifications would be suitable for school leavers and people who become visually handicapped as adults.

(c) With infants and very young children, Dr. Mary Sheridan's Stycar tests of vision (Sheridan 1973) and the Sheridan Gardiner test for young children aged $2\frac{1}{2}$ years and upwards have been very successful.

(d) There is increasing interest among teachers in the possibility of helping visually handicapped children with only a little vision to improve their visual perception (not their acuity) by means of graded exercises. Pioneer work in this field was undertaken by Dr. Natalie Barraga in the U.S.A. (Barraga 1964) and this work is being followed up in Britain under Schools Council funding at the Research Centre for the Visually Handicapped.

Some Personal Opinions about Vision and Visual Handicaps

I now turn to comments in which there is a high content of my personal opinion although I make no claim to be an innovator. I am simply putting forward ideas and suggestions based on many years experience with blind children and adults. I am sure that many people working with visually handicapped people and, I hope, many visually handicapped people themselves, will agree with much of what I shall say. My only claim to producing anything new is that I know of no other published material which contains such a presentation. It is my enquiry into the present circumstances of former Condover pupils which spurs me on to write in this vein.

"Static" Vision

I have thought for a long time that the visual acuity measurements which we have been considering can be described as estimates of "static" vision. The present ophthalmic definitions of vision are based on the subject being tested while remaining still. The test materials are at measured distances and remain stationary. The exceptions concern (a) the use of the hands and fingers of the tester in the assessment of very small amounts of defective vision when the testee may move himself closer to peer at the object, and (b) the measurement of near vision when print of various sizes is used as the testing material and the testee is allowed to adjust his position and his distance from the print, so that he can see it most clearly.

These two special cases are not really exceptions since they are mainly an exercise in finding an optimum distance between eye and test material and then maintaining it. Further measurements of vision with the objective of providing either normal spectacles or special low vision aids depend on the use of this optimum distance of clear focussing. This is very marked with low vision aids since alteration of the distance by a few millimetres may throw a clear, highly-magnified image right out of focus.

Low Visual Aids are composed of very special lenses or combination of lenses, which provide exceptionally high degrees of magnification. They are supplied to selected people only: those with very poor vision of such a type that they can be helped to read normal-sized print without any detriment to health or vision. Their use is usually confined (a) to partially blind people who need to read print as part of their occupations, but who would normally read braille, and (b) to those partially sighted people who, with spectacles, can only manage to read the specially produced large type materials. Low Visual Aids are also available for television watching. It must be stressed that, for many people with poor visual acuity, the Low Visual Aids are unsuitable because of the nature of the eye defect. There is no point in magnifying blurred or distorted images.

"Dynamic" Vision

We would really like to know something also about vision in action, sometimes referred to as "dynamic" vision or "visual efficiency". This implies things like field of vision, depth of vision, shifting of focus, use of peripheral vision, hand-eye co-ordination, and a person's movement in his visual field. A review published by the New York Social Science Research Council in 1953 included this statement: "It is the adequacy of each individual's vision for the particular tasks of his life that is crucial for a (somatopsychological) definition of blindness rather than optically measured visual acuity." I have placed brackets round the word "somatopsychological" since the statement is just as clear without this word. It is the emphasis on "the particular tasks of his life" which is important. I shall have this very much in mind when I give a simple classification of degrees of hnadicaps and then proceed to a discussion of the use of small amounts of vision and the substitution of the use of other senses where blindness is concerned.

Training of Residual Vision and Senses Other than Vision

It is understandable that people in the position of having to start dealing with blind persons should appeal for guidance from specialists with training and

experience in the education and welfare of the blind. It is reasonable for them to think that there must be specific methods of training of substitute senses and of residual vision which they could use with their blind "clients". However, I have passed nearly all my working life in the sphere of education of blind children and young adults and yet I know of no ready-made schemes of this type which I can recommend.

I certainly know of no systematic schemes of training visually handicapped people with a small degree of vision to use that vision more effectively, apart from the Barraga method to which I have already referred. This method, however, is concerned only with near vision with the limited objective of trying to develop the reading of ink-print in children with a very restricted degree of vision - children who, without the visual training, would not have learned to read. With the exceptions of the fairly recent development of sensory skills as an adjunct to the systematic training of totally blind people in mobility, mainly in association with the long cane technique, I know of no training schemes in hearing and orientation. However, these two schemes - mobility training and the Barraga method - may well be significant growing points in the training and education of visually handicapped people. I have not mentioned the long and honourable success of the Guide Dog scheme because this relies on the intelligent co-operation of a blind person with a trained dog rather than on the systematic training of non-visual sensory skills in the blind person.

What, one might say, no schemes of training of touch or hearing or of small amounts of residual vision! What have you teachers of the blind been doing? In our defence I should say that we have tended to treat each blind child as an individual and have tried to tailor our teaching to his special needs. We have fought shy of any detailed schemes of sensory training, thinking that they would be too stereotyped for individual children's needs, too restricting and boring for a child's use, and too academic and formal for the complicated needs of ordinary life. For instance, there has been considerable research into the sense of touch and one can imagine the development of a graded scheme of touch exercises based on neurological and psychological discoveries. Teachers might well claim that these would be uninteresting exercises for most children who develop their sense of touch by the use of some of the sensory apparatus of the normal nursery and infants schools, the simple games and activities of pre-braille-reading exercises, etc. I feel that I am struggling to justify teachers' attitudes which could be summed up thus:- the best method of sensory education is the informal guidance of children in these matters while they live as full a life as possible. Nevertheless it is my personal opinion that we have failed to include an element of research in our teaching programmes. We could improve our education of visually handicapped children by incorporating some of the findings of research and doing a little research ourselves on devising sensory and residual vision training schemes without detracting from an educational programme based on full-life experiences for the children.

Unfortunately we teachers and social workers of the blind may have contributed, consciously or unconsciously, to the development of an image of some very special mystique in the professions of the education and welfare of the blind. There certainly are specialist techniques such as the teaching of braille and mathematics, the use of teaching aids, etc., but these techniques are fairly easily acquired. Of equal importance are qualities such as good rapport, ingenuity, imagination, and patience. These are general qualities not confined to specialists in blind education and welfare. Perhaps our greatest specialist quality is that we have gained some realistic understanding of visually handicapped persons' problems and also of their potentials. The best way of acquiring this realistic

understanding is a lengthy period of experience with a fairly large number of blind people.

For most members of staffs of hospitals and day centres the possibilities of acquiring lengthy experience with blind people, or of receiving special advice simply do not exist. However, much can be accomplished by a person responsible for the care and training of a visually handicapped person through the exercise of ingenuity and common sense in analysing the blind person's capabilities and devising ways of helping him. I hope that the information and ideas which I am contributing in this chapter will be of some assistance. I think, though, that staffs should make their needs known to Social Services Departments. New Kinds of specialists for the visually handicapped are being trained and it may be that a specialist is available or will become so. The resources of Social Services Departments are limited but we ought to make known the legitimate needs of blind people so that these are not forgotten.

Three Categories of Visual Handicap

I have divided the whole range of visually handicapped people into three categories and I use this scale throughout the research survey. The division is rather obvious and is closely related to the ophthalmic grading of visual acuity. However, I shall examine each category in considerable detail with regard to the effect of defective vision upon people's life styles. The three categories are:-

1) People whose sight, though defective, is very useful and they are able to use it for most activities. As well as people classified as partially sighted I include in this group some people who are registered as legally blind, but are at the upper end of that visual acuity range.

2) People who, though correctly classified as legally blind, have some useful sight. Although the designation of 'partially blind' is not officially recognised, it is a useful description for people in this group who lie between the 'partially sighted' of the previous paragraph and the 'blind' of the next paragraph.

3) People whose visual acuity is so small that they must rely on other senses than sight. Obviously this group contains the totally blind but I include people whose visual acuities are classed as Light Perception and Hand Movements. I describe these people as blind.

For convenience and brevity I shall use the obvious initials of P.S., P.B., and B to describe the three categories of visual handicap.

I will consider some important spheres of practical living with reference to these three categories of visual handicap, ignoring additional handicaps. For convenience of presentation I have chosen two topics: Personal Independence and Mobility though there are obvious inter-connections.

Personal Independence

(a) Self-care Skills, i.e. dressing, washing, eating. All visually handicapped people should be completely independent, or nearly so, in these skills. Partially sighted and partially blind people should be able to use their vision except for a few partially blind whose handicap is severe enough to be borderline with blindness. With blind children the learning period will be longer, but with careful teaching, complete independence can be expected for most. A few minor

items may present difficulties and require occasional check-ups, for example personal appearance. There are sometimes slight problems with the manipulation of eating utensils such as the cutting of some rather hard foods which tend to "skid". In these matters, the obvious solution is for the blind person to ask for help or for a sighted person to ask if help would be welcome.

(b) The Work Area By this I mean the area within the reach of the hands, i.e. a space of approximately one yard square in front of the body with an extension of about one foot in each direction sideways. Many activities take place in this space with the person seated or standing in front of the work area, e.g. at meal times, at work, in leisure activities.

I would expect partially sighted people to be able to deal with this space visually - to recognise objects and move them around easily and accurately. They may need to examine things more closely than a person with normal vision, but this should not hinder any necessary manipulations.

Blind people need to deal with the work area tactually. The memory of the position of objects in the area is important. Careful movement of the hands is needed so that objects are not upset. Since the lack of vision slows down any quick positional checks, the work area should be uncluttered and it should be formally organised for ease of tactual manipulation. Some practice is essential for the development of confident movement. In my experience, there is a wide range of ability among blind people in the use of the work area, from those whose hands move around quickly and accurately as if guided by a mental picture of the area, to others whose hand movements remain tentative and haphazard.

Partially blind people use their sight but they may have to get the face quite close to see smaller objects and even use touch at times. They have to build up their own combined visual-tactual method of dealing with the work area, or be helped to do so.

(c) Home Management Skills The ultimate objective in personal independence training is ability to live independently in one's own home either as a married person or as a single person in lodgings, or bed sitter, or in a flat. There is a sex difference here since full-scale running of a home is usually a woman's job, including cooking, cleaning, and laundry, while a man's activities tend to be of the nature of that domestic help which a good husband or son would give at home. I am aware that this statement is a somewhat sweeping assertion and that some visually handicapped young men follow the present tendency of seeing young men to become more skilled domestically.

How realistic is it to expect that visually handicapped people can become skilled in home management? As far as partially sighted people are concerned there seems no reason why they should not manage these skills as well as a normally seeing person, provided they are given some encouragement and they themselves take a little extra care.

Blind and partially blind people need more specialised training, though many partially blind people acquire this informally. For the really blind, there would appear to be some insuperable difficulties in situations where sight seems to be an absolute necessity e.g. the finer aspects of house cleaning, vegetable preparation, etc. However, the number of practising blind housewives shows that lack of sight can be compensated for very successfully. Factors contributing to this success include the personal traits of courage, a desire for independence, and a will to succeed. In addition, above-average skills

in manual ability and in sensory compensation for the lack of sight are needed. There are educational provisions which make their contribution: many schools for the visually handicapped provide Domestic Science courses for boys and girls. One of the national vocational assessment centres for school leavers has a detailed course of social techniques, homecraft and household mechanics. The R.N.I.B.'s rehabilitation centres provide courses for blind housewives and in homecraft skills for men, too. The remarks I made above concerning a planned and uncluttered work area apply even more in the wider sphere of home management skills. Tidiness in the house, so that movement between work areas is easy, is very important. For blind and partially blind people there has to be an element of operational research about their approach - and that of their teachers or advisers - to achieving success in work and household operations. What I shall write in the next section about Mobility is relevant to this topic. A BBC publication entitled "In Touch" gives much useful information about Home Management and Mobility.

Mobility

This term is used to describe the independent movement and travel of visually handicapped people. Normally the aspect of travel is emphasised, but I wish to consider mobility in smaller areas, e.g. home, work, etc. and what I say now will link with the material of the previous sections on work areas and home management. At first I shall concentrate on blind people but will deal with the partially blind and partially sighted later.

I will begin by discussing two phenomena concerning totally blind people which, for lack of a more precise definition, I will call "innate skills". I refer to object or obstacle detection and orientation.

By the orientation of the blind I mean their awareness of their own position in space, their ability to move about in it, and the fact that they achieve some form of conceptual organisation which makes their environment understandable. Obviously, repetitive practice in movement with the largely unconscious development of kinaesthetic memory - bodily movement memory - help to form a pattern of orientational skills. Sound and touch clues are also important in understanding the environment.

The term 'object' or 'obstacle' detection - sometimes the expression 'obstacle sense' is used - refers to the ability to detect the presence of an obstacle at such a distance that physical contact with it can be avoided and the ability to detect the presence of objects without having to touch them.

To illustrate the points I am making I will describe a true incident. I remember vividly at school seeing Pat, a totally blind girl aged 15, who had two artificial eyes, give the following example of good mobility which was simply part of her daily living, and she did not know that I was watching her. She ran quickly down the middle of a wide staircase, not holding the rail. At the bottom she turned left and walked quickly 10 yards to a wide opening and, going through the middle of this, went into the school hall. She passed through the hall, which is about 20 yards long, keeping about three yards from the wall on her right. On approaching the wall at the far end of the hall she swung confidently to the right into a short but broad passage, then, putting out her hand, she found unerringly the handle of the closed door of the room where she was due for a lesson. Admittedly Pat was exceptionally gifted in independent movement, being one of that small number of blind people, well known among blind people and those who

work with them, as having outstandingly good natural mobility, very quickly acquired. Probably it is people like this who have given rise to the popular belief in some "special sense" of the blind.

To return to Pat, as she walked quickly to her class, we note these facts: Her orientation was good, "she knew where she was going", being unconsciously aware of distances, where to turn and in which direction. Her obstacle sense was providing clues about the opening into the hall, the distance of the wall on her right, the position of the end wall indicating the need to turn right, etc.

This report is not the place for a detailed discussion of these matters and I must confine myself to a series of statements which are relevant to the purposes of this chapter. I just add that the topics of obstacle sense, orientation, and mobility have interested me for many years. I have had the pleasure of collaborating with a blind friend, who is one of the specially gifted people to whom I have referred, in a detailed research into the Obstacle Sense of the Blind. Therefore the eight statements I now list are based on something more than personal opinion.

1. There is no need to postulate a special sense of the blind. The special skills of blind people are developments and variations of abilities which are present in all people. Seeing people have no need to develop those non-visual aspects of abilities which are forced upon the blind because of their lack of sight.

2. Blind people build up their orientational pattern — their "picture of their environment" — through non-visual information: from touch; from smell, e.g. identification of some shops, permanent sources of odour; from hearing, e.g. identification of places through sound location such as kitchen and other household noises and similarly from frequent noise emitters outside, direction of flow of traffic, characteristic sounds of enclosed or wide open spaces. All these sources of information are available to seeing people, who normally prefer to use their sight.

3. This leaves the rather special case of the obstacle sense which can, however, be explained as a special function of hearing. This is not a conscious interpretation of echoes from an object in the normal way but some aural awareness of obstacles through the changing pattern of sound at some level of hearing not yet understood. A simple proof of the statement that the obstacle sense is concerned with hearing is that, in noisy surroundings, obstacle detection is impossible. If a radio had been blaring loudly, Pat would have lost her sureness in movement.

4. I feel sure that the obstacle sense is present in seeing people and it can be developed by seeing people to some extent after some practice with vision completely obscured.

5. Obstacle sense is developed best in children born blind or who become blind at an early age, probably during the first six or seven years of life.

6. The exceptional natural mobility, combining obstacle sense and orientation, developed in some individuals occurs in children who had sight for some time but had lost it before the age of five. There are no research or statistical findings confirming this statement, but there is a considerable amount of circumstantial evidence supporting it.

7. Although there is a very wide range in the natural obstacle sense and orientational ability in blind children the great majority use them in localised mobility in the intimate environment of home.

8. People who go blind after they have established a visual way of life are faced with a different problem. Their visual "picture of their environment" persists after the onset of blindness but there is only a slow development of obstacle sense, and the newly blinded have to rely on more "artificial" training than the more "natural" training of blind children. The rehabilitation process is slow and skills are learned to allow the blinded person to maintain as far as possible the way of life to which he was accustomed.

Mobility Training and Aids

Before attempting a brief summary of the mobility of visually handicapped people, it will be helpful to give a little information about mobility aids and training from the point of view of independent travel. All blind people, even those well endowed with what I have described as natural skills, need some form of mobility aid for travel beyond the home environment.

The short white cane. This has largely replaced the traditional white walking stick. It serves as a convenient reminder to the general public that the person carrying it is blind. It can also be an effective probe for use in mobility in the avoidance of obstacles and the recognition of useful clues, e.g. kerbs, walls, changes of surfaces of pavements.

The long cane is a more recent development which is planned specifically as a mobility probe. Training in its use is accompanied by detailed education in mobility. The cane's length varies according to its user's height and is normally the distance from the breast bone to the ground. The systematic mobility training programme associated with the long cane began in the U.S.A. and is now being developed in this country. A consortium led by the R.N.I.B. has set up a National Mobility Centre which trains teachers of mobility but not individual blind people. School teachers and Social Workers have been trained, and are still being trained, and thus the new techniques are being carried to school children and adults.

Guide Dogs. The Guide Dogs Association offers training which is selective and thorough. The selection criteria include a blind person's ability to use a trained dog, which involves considerable skill, and to care for the animal. Guide Dog owners are active people who, through work commitments or leisure time interests, can give their dog the exercise and reinforcement of training which it needs.

The Kay Ultrasonic Torch. This sophisticated apparatus is based on the emission of ultrasonic sound which is reflected from objects to a receiver in the torch. The reflected ultrasonic sound is converted into audible sound which is conveyed to a plug in the user's ear. The torch is not used by many people. The interpretation of the incoming sound clues, which vary in pitch according to the distances of objects, is quite complicated. Effective torch users are enthusiasts who are prepared to spend considerable time in training themselves in its use. The latest development has been the incorporation of the emitter and receiver into a spectacle frame which connects with the ear plug.

Mobility and the Visually Handicapped - A Summary

Partially sighted people should be able to use their vision. Though some guidance and a little training is advisable they should have no need for the mobility aids I have been describing. If they do need these aids I consider that this is an indication that they are really partially blind rather than partially sighted.

Partially blind people may well be able to use their vision for some aspects of independent travel and it is easier for them to extend the area in which they normally travel than it is for blind people. Nevertheless they need some form of mobility training and a mobility aid. It is probable that in some cases a short white cane is the appropriate aid, but other people might well profit from the use of the long cane.

Blind people should be independently mobile at home and in its immediate environment, i.e. shops, bus stops, etc. The extent of independent travel beyond this area depends on many factors, such as the type of mobility aid used, the actual need for this longer distance travel, i.e. work and leisure time commitments, and the personal desire for extended independent travel. There is no need for independent travel if personal companionship is available and enjoyable - perhaps the best mobility aid is a sighted spouse! So much depends on personal circumstances and inclinations. Some blind people travel long distances using taxis, public transport, porters, and the occasional help from strangers.

Note on the Multi-handicapped

In this first section of the Chapter, I have been dealing with visual handicaps mainly in the context of people who have no handicaps additional to their defective vision. My report is concerned, however, with multi-handicapped blind people and in the next section I shall discuss the other types of handicaps. I want to point out now, especially to anyone concerned with multi-handicapped blind people i.e. parents, friends and professional workers, how important it is to help to minimize the effects of such people's blindness and encourage the maximum possible independence.

SECTION B: THE OTHER HANDICAPS

For 20 years after the opening of the school there was considerable pressure on places at Condover. There were always children on the waiting list for admission and this led to fairly frequent reviews of the children already in school. We had to make difficult decisions concerning the admission of children who seemed suitable for education at Condover with the consequent discharge of some children already at school who seemed less suitable for education there. There were two main groups of children considered for discharge:-

(a) Those who could be transferred to schools for less seriously handicapped children - schools for the blind, schools for the partially sighted and, occasionally, schools for the educationally subnormal. It was very gratifying for the staff to be able to promote less seriously handicapped pupils of this type.

(b) The very seriously handicapped who did not seem to be profiting from education, even at the very low academic level of one type of programme which the school provided - and still provides. One factor which made it difficult for us to decide that children should be dismissed was the fact that only rarely was there any alternative placement available and consequently parents would be faced with the full-time care of their extremely handicapped children. Decisions about these matters were always taken after full discussion in staff meetings and often there were sharp divisions of opinion about children's discharge. Occasionally, the case presented on medical grounds by the school doctor had to be accepted. At other times a majority vote seemed a satisfactory solution for decision making. One of the benefits of a democratic method of school organisation was that, in a few cases of great difficulty, it was amicably agreed that the decision should be taken by me.

I will now attempt a classification of the children's handicaps, additional to blindness, by type and severity. This will be useful as a global description of the kind of children who are educated at Condover and also, when I come to the detailed examination in my research survey of what happens to individual children when they leave school.

It must be stressed that each individual child, apart from his handicaps which can, to some extent, be described, has his own particular characteristics which are impossible to define. The total personality is far from being a mere catalogue of handicaps.

Classification of Handicaps

I shall use the obvious three-fold broad classification of Intellectual, Physical, and Emotional Handicaps, with some sub-division where necessary. It is obvious that these three areas of handicap are not independent entities, and there is much overlapping of boundaries.

Although, at Condover, we tried to keep aware of theoretical pronouncements concerning the education of handicapped children and other people's practical experience and experiments, we probably did not profit as much from these as we should have done. As a partial defence of this deficiency, I suggest that we were very busy in the practical work of running a residential school and we were dealing with a group of children with such varied handicaps that at first, we felt rather isolated from normal streams of educational practice and theory. My classification is based, therefore, largely on my practical experience supported by the experience and ideas of many members of staff at Condover. I acknowledge also the interest and encouragement of many teachers of the blind, and, in particular, a few administrators and education specialists who, from time to time, gave me opportunities to publicise the kinds of thing we were trying to do at Condover.

Intellectual Handicaps

In some ways this is the easiest of the categories to describe. Certainly it is a simple matter to enumerate sub-divisions of intellectual handicap, fairly closely related to measurements and estimates of intelligence quotients. Since one of these sub-divisions is the "normal range of average intelligence", there are only three sub-divisions of intellectual handicap in my classification and these are almost identical with the accepted grouping of intellectually less able children:- the educationally sub-normal and the severely sub-normal, though I have sub-divided the educationally sub-normal into two sections - the "high grade" and the "low grade".

The Williams Intelligence Scale is widely accepted as an effective measure of the intelligence of visually handicapped children. I used the scale myself in assessing approximately 200 Condover pupils and found it a very useful guide, though broad indications of level of intelligence were often more useful than the apparently 'precise' indices of intelligence quotients. Later the intelligence testing was taken over by another tester. There was only a little re-testing by him of children I had already tested so there was little possibility of large-scale comparison of our results. However, using the criteria of children's general behaviour in the class situation and in social life, our measurements were broadly similar with one important exception. The new tester carried out tests with a considerable number of children near school-leaving age and this group contained a number of boys and girls whom I had tested four or five years previously. In

some children he found a marked decrease in I.Q. score, particularly in the less able. For example, some children who at about age 12 had I.Q's. in the region of 60, at age about 16 only scored 50 or even a little below.

I have consulted Miss Myfanwy Williams, the author of the Williams Scale, about this. She tells me that she is aware of this kind of apparent deterioration, which she has attributed to the nature of the scale. She thinks that, from the age of about 12, children of low intellectual ability do not seem to develop or mature in some of the abilities which the test measures. The test was devised for visually handicapped children and, naturally, has a particular emphasis on verbal ability. The tests at the higher end of the scale, while suitable for children of average and superior intelligence, are less suitable for "non-academic" children. Miss Williams agrees that, if there are no marked personality changes or variations in general standards of school work in these children of rather low intelligence there is no reason to consider that there is a real decrease in intelligence even if the change in I.Q. score on her scale seems to indicate this. She is in agreement with the classification which I give below, emphasising that my statement that test results are more important in indicating broad levels of intelligence than a strict adherence to specific I.Q. measurements is very much her opinion too.

My four categories of intellectual handicap are:-

Handicap - Nil Pupils within the range of "average intelligence", i.e. without a marked intellectual handicap. For my purposes this means people with an I.Q. of approximately 80 and above. I found that, on the whole, blind children with other handicaps seemed to make an intelligence score a little lower than I expected. If a tester interprets children's answers strictly according to the rules laid down in the test, the resulting quotient can be stated to be a minimum score. I certainly did not give children the benefit of any doubts when I scored their responses. In making the classification of Nil Handicap, I used, at first, the lower border-line of I.Q. 85, but have changed to the limit of I.Q. 80 in view of the argument I have already mentioned. In effect the children in this group are those who, if they had suffered from no other handicap than the visual one, should have been educated with visually handicapped children of normal ability. Incidentally, only three Condover pupils were of above average intelligence.

Groups A and B Pupils who could be described as "educationally sub-normal", though I would prefer to use the term "intellectually handicapped". An approximate I.Q. range for the two groups combined is 50-80. At first I thought of including all the children in this range in one group. This would have made my task of allocating pupils to categories of intelligence fairly easy and I could have used a general statement to cover the group, i.e. "Regardless of any other handicaps, children in this group need a special educational programme like that provided at Condover". However, the variety of ability in so wide a range of intelligence indicated by the I.Q. spread of 50-80 is very great. Children near the top of the range, although they will probably not become literate, can use language quite well and are very different in their methods of learning from children at the lower end of the range. As they near school-leaving age they can think abstractly to a certain degree, while their less able friends have not moved far from the stage of concrete thinking. Therefore, although I was posing myself some selection problems about border-line placement of a number of children, I decided that I must use two categories with the demarcation area of I.Q. approximately 65. Thus we have Group A for the upper division and Group B for the lower. To avoid the use of such unfortunate phrases as "high-grade E.S.N." and "low-grade E.S.N." I define Group A as having "a moderate intellectual handicap" and Group B as having "a severe intellectual handicap".

Although these phrases are vague and may not please people who would like more objective measurements, I find the general concept of "intellectual handicap" very useful in thinking of people whom I knew quite well as children and when I come now to assessing their abilities years later as adults.

Group C This group consists of pupils who are usually thought of as being "mentally severely sub-normal" though I would prefer to use the term "very severely intellectually handicapped". As far as intelligence ratings are concerned, these people have an I.Q. below 50. We always had some children at Condover of this low level of intelligence. Until 1971 when, for educational purposes, all children became the responsibility of the Department of Education and Science, children like these would have been eligible for admission to a Junior Training Centre administered by Local Authority Health Departments. There were no J.T.C.'s specialising in visually handicapped children, but some Centres occasionally admitted a blind child. There is some evidence that the new day special schools which have replaced the J.T.C.'s are admitting multi-handicapped blind children of what I have called Grade C of intellectual handicap. At Condover some children in this category were given a fairly long period of education but they were obvious candidates for dismissal when places had to be found for children on the waiting list. I am happy to think that a few severely intellectually handicapped children stayed on till school-leaving age and that Condover continues to give sympathetic consideration to this type of child.

Physical Handicaps

Although approximately three-quarters of children at Condover with physical handicaps suffered from cerebral palsy, there were smaller numbers of children affected by crippling defects of other types:- forms of arthritis; muscular dystrophy; poliomyelitis; brittle bone conditions; after-effects of accidents; cerebral tumour; meningitis, etc. There was even one boy with spina-bifida, a fore-runner of the young blind spina-bifida children who are a small part of the great increase in recent years of 'seeing' children with this serious condition.

Cerebral palsy indicates defective functioning of the muscles because of faulty nerve action that is due to some damage in those parts of the brain which control muscular action. Although the most obvious and frequent effect is on the limbs, it can also affect other muscular systems, e.g. swallowing and speech. Cerebral palsy is used to describe the condition which has its origin in the embryo during pregnancy or in an infant at birth or in the neonatal condition.

There are three main forms of cerebral palsy. Normal movement of limbs is achieved by the intricate balance effected by nerves controlling the contraction and relaxation of opposing sets of muscles. In spasticity the contracting system is over-active and there is a failure of function of the relaxing muscles. In ataxia the reverse is true with the relaxing system over-active and a failure of function of the contracting system. The third type of cerebral palsy is athetosis the effect of which is the frequent recurrence of unwanted muscular movements such as writhing of arms, jerking of head and neck, etc., which are a severe hindrance to normal muscular development. Often, in athetosis the development of speech is impossible. The three types of cerebral palsy are due to the different placing of the damage in the brain. If the damage is localised it can give rise to one type of cerebral palsy; if it is more general the symptoms may be a mixture of two or three types.

The actual physical symptoms in children are very varied and in describing them I shall base my statements on the children I knew at Condover, all of whom

were, of course, visually handicapped. The most common type of cerebral palsy is spasticity and we had more spastics than children affected by all the other physical handicaps combined. I suppose most people's mental image of a paralysed limb is an arm or leg which is very stiff, possibly bent, possibly shorter than normal. This is, in effect, the description of a typical spastic limb. Spasticity can cause malfunction in any or all of the four limbs and the severity of the defect can vary greatly. At Condover the number of children with spasticity in one limb or in three limbs was very small. More frequently it occurred in all four limbs (quadriplegia) or in the arm and leg of one side (hemiplegia). There were also several children both of whose legs were affected but whose arms functioned fairly normally (diplegia). We had no children both of whose arms were affected but whose legs functioned normally.

As far as the severity of spasticity in a limb is concerned there is a great variety in degree which is particularly obvious in the arm and hand. A severe type of spasticity keeps the muscles completely contracted. This inhibits growth in the arm, which is wasted in appearance with the hand and fingers severely deformed and having no effective movement. With a slightly less severe degree of spasticity the arm may reach near normal length, and, though the hand is incapable of any fine finger-movements, the limb as a whole can be used as a stopping or pushing tool in a rather gross fashion. If the other hand and arm are normal, this type of spastic limb has limited but, nevertheless, effective use. Slight spasticity in an arm can mean a fairly normal-looking limb with a fairly useful hand which, with practice, can become a clumsy but quite effective tool.

A severely spastic leg can be so deformed that surgery to straighten it and to give it even a small amount of movement is impossible. People with such a leg or legs will only be mobile in a wheelchair and even then this pre-supposes that they have some effective use of at least one arm. Fortunately only two of our spastic children were as seriously handicapped as this. It is to be expected that children with slightly less spasticity than this will have legs which, with or without operation, will be aided by the wearing of leg calipers. Training and experience with calipers plus the variety of walking aids now available can lead to some restricted but very important independent walking. Eventually they may progress to walking with a stick or crutch, or two of these, within a house or outside in a well-known environment with no serious obstacles. Children with a slight degree of spasticity in the legs are able to walk reasonably well, without sticks but in a rather stiff, ungainly manner. Under favourable circumstances they may walk unaided for a mile or even two.

I have made clear, I hope, how varied the effect of spasticity can be and there is the additional complication that, in the same person, there may be considerable differences in the severity of the defect in different limbs. The two most vital factors are (a) the extent of the effective use of hands and (b) independent mobility. I do not wish to prolong unduly the discussion of the functional variety in physical handicap. I will, therefore, add brief observations before coming to a statement of the classification I have decided to adopt.

Ataxic children, with their relaxed flaccid musculature, have considerable difficulties in balance. Most of our ataxic children were quite seriously affected in all four limbs and were unable to walk. Some had a degree of spasticity as well. The less seriously affected were able to walk on a wide gait but uncertainly and with balance difficulties.

We had no athetoid children. Occasional references were made in case notes to possible athetoid features, but these were not serious.

Children with physical handicaps diagnosed as being due to other causes than cerebral palsy showed great variety in physical malfunction. A few, in fact, had spasticity or ataxia as a consequence of cerebral tumours or cerebro-neurological diseases acquired in childhood after some years of normal muscular development. The others with different types of physical handicap have basically the difficulties of function which I have covered in my remarks on cerebral palsy.

A Three-fold Classification

This is based on increasing severity of mal-function and not on medical diagnosis. It is difficult to isolate the effects of physical handicap from those of visual handicap since sight is so important for achieving mobility and maximum use of hands, particularly with physically handicapped children. I have tried to minimise the factor of vision in the classification and to concentrate on the effectiveness of the residual physical abilities.

It is possible that in allocating children to the three categories I have tended to under-estimate the severity of the physical handicaps. Perhaps some children whom I have placed in the"Nil" category could have been placed in category (a). I have left out of consideration some clumsy children who might have been diagnosed as suffering from minimal cerebral dysfunction. Although this type of handicap is not obvious and is difficult to define, it can, nevertheless, present severe difficulties to children suffering from it. However, I have not included them in the categories of physical handicap.

Category (a): Moderate Handicap. People in this category usually do not need any help in self-care. They are fairly mobile, being able to walk independently indoors. They can walk alone fairly confidently for several hundred yards outside in safe, well-known areas. With help they can walk, say, two miles and they can use public transport with little or no help. They have fairly effective use of both hands or very effective use of one.

Category (b): Severe Handicap. When I have included a person with good use, or fairly good use, of hands in this category, this is associated with poor mobility. Walking is restricted to the home or indoors in small, well-known areas. In some cases independent walking for short distances near home is possible. Walking aids are usually necessary and a wheel chair is often needed. When I have included in Category (b) people with better mobility than this though not as good as that described in Category (a), this is associated with poor use of hands. The majority need some help with some aspects of self-care. Only a few very persistent people with desire to achieve independence are able to attain near-independence in self-care.

Category (c): Very Severe Handicap. The criteria for placement in this category include almost complete lack of independent mobility and very poor manual ability, which implies the need for much help with self-care. In a few cases I have allowed fairly frequent pain to be a reason for placing in Category (c) people who have fairly effective but restricted use of their hands. Almost inevitably a wheel-chair is needed, even indoors. Since I do not wish to use the term "very severe" where it is not justified, I have just reviewed the cases of the 27 whom I have placed in Category (c) in the "At School" summary. Six of these are near the borderline with Category (b) but the other 21 are severely handicapped indeed.

Emotional Handicap

It is to be expected that visually handicapped children and adults may have more difficulties with social and emotional adjustment than seeing people. A survey of blind and partially sighted children carried out by Dr. S. R. Fine showed that teachers of blind children considered that 36 per cent of their children were emotionally disturbed. Thirty-two per cent of partially sighted children were considered by their teachers to be emotionally disturbed. These figures are quoted in the Vernon Report where there is also a short discussion about the nature, prevalence, and possible treatment of emotional disturbance. (Paragraphs 3.26, 3.27 and 3.28).

In a school for additionally handicapped blind children, one would expect there to be many children with behaviour problems and this is certainly true at Condover. Numerically the most important handicap additional to blindness was - and is - the intellectual handicap, but the problems arising from the children's emotional disturbance posed the greatest difficulties. For the Condover research survey I have decided to use a simple method of classification of some of the manifestations which we had at Condover: uncontrolled physical and verbal aggression; almost complete withdrawal; repetitive and obsessional talk and action; bodily mannerisms; an inability to appreciate reality; overdue seeking of attention and affection. Some of these symptoms seem specially allied to blindness but most are evident also in autistic children and in severely intellectually impaired children. At one time - in the early days before I had gained sufficient experience - I was boldly prepared to say that I could distinguish between emotional disturbance due to unusual factors in the early life of children and the more nervously erratic behaviour which could be attributed to "brain damage" or neurological upsets. But we were confronted with the problem of dealing with disturbed children in the day-to-day situation of running a school with no possibility of regular psychological and psychiatric aid.

The two most helpful psychiatrists we had both attended rarely and stressed that our actions at school were more important than infrequent treatment by a specialist. One psychiatrist said that the atmosphere of the school and the attitudes of the staff were comparable to those of a good clinic. He made this statement in a full staff meeting and it had a very reassuring and heartening effect on the staff. A later psychiatrist was prepared to prescribe treatments - mainly through medication - but he insisted that he must have as full a description of symptoms as possible plus reliable feed-back about response to treatment. If only this man could have attended school once per week instead of two or three times per term! Mostly we were "on our own" with these difficult problems.

The question of terms to use in describing these emotional handicaps has always created problems for me. I have felt unable to distinguish effectively between psychiatric and neurotic disorders, between conduct and developmental disorders, "psychological" and "brain damage" disorders, etc. What global term can be used to describe the whole area? For the purposes of this research survey I have decided to use the term which I normally used at school - "behaviour handicaps". Since the major difficulty for children and adults suffering from these problems is that of adjusting to the society in which they live, I was tempted to use the term "maladjustment". For statistical purposes I have decided to rely on the simple distinction between two levels of severity of behaviour problems and to help keep to the forefront the concept of maladjustment.

Category M, very severe handicap denoting those children whose behaviour was so abnormal that it interfered seriously with education and social life. These children found it very difficult - sometimes impossible - to adjust to life. Such a handicap was considered by staff to be a child's most serious handicap, more difficult to deal with than blindness;

Category m, severe handicap denoting a less severe condition than M but, nevertheless, a handicap which posed considerable difficulties in children's adjustment to the society of school and home.

Deafness

It is possible here to distinguish between two types of deafness through the method of educational treatment of children at Condover.

Category D/B denotes those children who were educated at Pathways, the school's special department for so-called deaf-blind children. I use the word "so-called" because although a few children were truly deaf and blind, the majority had some useful vision though deafness was generally more severe. The very severe problem posed by Pathways children was - and is - that of severe difficulties of communication, often due to brain damage of which the visual and oral defects were only a part. The former pupils of Condover who, in this research survey, are listed as D/B, have either no effective system of communication or have to rely on the use of the deaf-blind manual.

Category (d) denotes children who were educated in the main school at Condover, i.e. with hearing children. These people, now adults, can be described as "hard of hearing". Some, though not all, use a hearing aid. They are able to communicate by means of speech, but their hearing handicap causes quite severe difficulties. Because they hear many things, it is often assumed that they have heard conversation, instructions, announcements, which, in fact they have missed. As children, their education was often hampered quite seriously by a hearing loss which, superficially, seemed quite minor.

Epilepsy

When the school opened it was officially stated that children suffering from epilepsy would not be admitted. Nevertheless some epileptic children were admitted since the fact that they suffered from this trouble was not revealed on the application forms. The staff were not happy about discharging these children and the exclusion of epileptic children was discontinued. In the first few years of the school's existence a major fit from one child or another occurred once or twice a week. Treatment of epilepsy through medication has improved so that actual epileptic attacks in the school are now very infrequent. Some children when admitted had a history of epilepsy which seems to be controlled by drugs yet many of us felt that "submerged" epilepsy or, possibly, the drug treatment, had an ill effect on the behaviour of some children.

It seemed important that the research survey should take some note of the prevalence of epilepsy, but a detailed study was impossible. Apart from the general difficulty of gathering reliable information, there are many complications such as type and severity of fits, their frequency, and medication, which would have made systematic recording very difficult. In the statistical tables I shall simply indicate the presence of epilepsy of some form. In some subsections of the research report I shall, however, give some more detailed information in the discussion of statistics, distinguishing when possible between active epilepsy, epilepsy under complete control and under partial control, plus indications of cases in which medication has ceased and epilepsy has not recurred.

Brain Damage

At first it seemed useful that I should record any well authenticated medical evidence that blindness was the aftermath of brain tumour, encephalitis, meningitis, familial syndromes etc. There are many uncertainties in the definition

and diagnosis of brain damage and there is the added complication of cerebral palsy and the rubella syndrome where the visual handicap can be either quite fortuitous or part of the widespread effect of a virus.

I am quite unsure of my own understanding of this complex subject and I decided to delete statistics concerning brain damage, except in the cases of people who are in hospital.

CHAPTER 3

PEOPLE IN HOSPITALS

Review of Contents of Chapter

After a short introduction, which includes some of my emotional reactions to the hospital situation, I give in Table 3.I some information about the handicaps of the 41 Condover ex-pupils who are in hospital.

Shortly afterwards I begin an enquiry concerning the validity of these people's placement in hospital, examining first the cases of 31 who might be considered as correctly placed there. I do this by outlining the serious handicaps of these people using a few illustrative case descriptions.

There is a brief, but important, discussion of the definition of mental handicaps according to the Mental Health Act of 1959, with some indication of the relevance of my categories of intellectual and behaviour handicaps.

The mention in the Act of the importance of the ability to live an independent life, prompted me to introduce some information about the ex-pupils' abilities in self-care which is summarised in the histogram which forms Table 3.IV.

Using case descriptions, I discuss the cases of 11 people who could be considered for promotion from hospital because of the comparatively minor severity of their handicaps and their relatively high skill in independent self-care. This section finishes with my final assessment of the people and their classification into high and low priority groups for promotion.

After the presentation of some miscellaneous statistics on occupation, leisure, visitors and holidays, and liaison between Hospitals and Social Services, I begin a rather lengthy summary. The length of this section is due to my desire to give some life to the summarising process by describing a Blind Unit in a hospital and the only case of a successful rehabilitation of a blind ex-pupil formerly in hospital.

A short statistical summary and a list of recommendations complete the chapter.

People in Hospitals

Preliminary enquiries in 1971 revealed that 40 ex-pupils were then in hospital. During the period of the research two further people were admitted to hospitals because of increased difficulties of health and behaviour. One of the original 40 now lives in a Local Authority hostel and attends a day Adult Training Centre for the Physically Handicapped. Statistically he will be treated in the chapter dealing with day centres, but he will be the subject of a case study at the end of this chapter on hospitals. Another man from the original 40 has been transferred from a large hospital to another smaller establishment organised on a hostel basis but still under the supervision of a Regional Hospital Board. This man will be included in the people being considered in this chapter. The revised total for those in hospital is, therefore, 41.

The procedure for the investigation of these people was two-fold; a personal visit to each former pupil was followed up with two questionnaires to hospital staff. One questionnaire sought information from medical consultants while the

second was addressed to members of the nursing staff closely involved with the subjects of the research. The complete procedure was carried out for 37 of the 41 ex-pupils. One other man was visited at his hospital, but the questionnaires were not returned inspite of two tactfully worded reminders. I was unable to visit the other three ex-pupils, all of them men, but I received adequately completed questionnaires for two of them.

Hospitals

The number of hospitals visited was 33. The discrepancy between the number of hospitals visited and the number of people seen is due to the fact that four hospitals have more than one ex-Condover pupil. Most of the hospitals were dealing with severely mentally handicapped people, i.e. the severely subnormal, but not with the mentally ill. Two residential establishments for epileptic people have been included.

For my wife and me the visiting of hospitals has been an experience fraught with emotion. As the visits have continued we have passed through feelings of repugnance, irrational pity, and something near fear, towards some sort of understanding of the difficulties, illnesses, and defects of the patients, together with a kind of distressed acceptance of the very unsatisfactory conditions in which most of them have to live. We have also worked through an unthinking, over-emotional attitude towards the "dedication" of the hospital staffs to a more rational appreciation of their situation. They are members of a profession who are, in the main, compassionate, realistic, are becoming increasingly well-trained and are doing good work in far from ideal conditions.

I have found it difficult to plan the presentation of this chapter and I find it necessary to begin now by discharging, as it were, an accumulation of latent emotion when I consider the hospitals. If more people realised the conditions in which we, as a civilised community, care for our mentally handicapped, hospitalised men and women, we would begin to take more positive action to ameliorate those conditions. We would warmly support the efforts which the staffs of most hospitals are making to improve the life of the people for whom they care on our behalf. In nearly every hospital I have visited I have seen successful attempts to humanise and domesticate the huge, unsympathetic buildings which were once considered suitable for "mental asylums". Old buildings are being adapted and sometimes simple, new, prefabricated buildings are erected to serve as clubs, canteens, or recreation centres for the patients. Brighter furnishings, modern, more comfortable, furniture are being provided in smaller, partitioned bedroom units which have been devised within the former huge wards. Some of these improvements are provided from the hospital revenue, others result from charitable efforts organised by hospital staff or by the organisations known as "Friends of the Hospital". Occasionally help and/or money is provided by charitably-minded clubs and organisations who have been alerted to the needs of the hospitals, and their residents. However, there is never enough help, never enough money, and I think that a really civilised community would do much more to see that these needs were met much better than they are now. Imaginative, progressive major projects have already been devised by hospital committees and staffs which could make significant improvements in regional hospital areas. Lack of finance means indefinite postponement.

At this juncture I start by listing some of the improvements which medical consultants would like to see in their own hospitals. One section of their questionnaire invited them to list two improvements which they deem urgent. Perhaps I worded this section insufficiently clearly. Certainly not all consultants made suggestions but the twin topic of decrease of over-crowding

of patients and improved staff-patient ratio was mentioned frequently with special reference to individual ex-Condover pupils and was also emphasised as a general need.

Reasons for Placement in Hospital

Why were the 41 Condover ex-pupils placed in hospital? Are they correctly placed there? I will deal with these questions in some detail, since they are relevant to all blind people in hospitals for the mentally handicapped of whom the ex-Condover pupils form a very small percentage. In fact the questions can be asked also about a very large number of seeing patients whose handicaps are not severe enough to warrant their retention in hospital.

When we visited our former pupils in hospital we were relieved to find that many seriously handicapped ex-pupils had found places there. We were aware, however, that a few former pupils seemed wrongly placed in hospital and that they should be able to manage to live in the community, especially if they had some form of occupation during the day. It is well known that hospital staffs are campaigning for the transfer of suitable patients to hostels or other accommodation in the community..

In the consultant's questionnaire I posed three questions on this topic, specifically relating it to the former Condover pupils: "If facilities were available could X be 'promoted' from hospital?". "If so, what facilities would be suitable?", and "Is X rightly placed in hospital?". Thirty-nine questionnaires were returned and the consultants considered that 13 of our people are suitable for promotion while 28 are correctly permanently cared for in hospital.

There are two other ways in which I can evaluate this situation. Firstly there are the people now in hospital who, at school leaving age, would not have been considered by the school staff and me to be in need of hospital care. Secondly, I can compare the present situation of each individual in the light of my knowledge of their school performance and of the information gained from the present circumstances of the 314 people who form the basis of my research.

Before pursuing this topic further I will examine the general statistics given in Table 3.I for all the Condover people in hospital. Discussion of my method of classification of the handicaps will be found in Chapter 2. A summary is printed on page 36, and a copy of this is provided on a bookmark for convenience of reference.

Table 3.I People in Hospital (N=41). Average age 28.3 Age range 17-41

		Hospital	For Comparison
Sex	M	23	25
	F	18	16
Vision	PS	8	10
	PB	15	13
	B	18	18
Intellectual Handicap	Nil	0	8
	A	4	17
	B	13	11
	C	24	5
Physical Handicap	Nil	31	29
	a	2	4
	b	5	5
	c	3	3
Behaviour Handicap	Nil	12	27
	m	8	9
	M	21	5
Deafness	Nil	31	35
	d	0	3
	D/B	10	3
Epilepsy	-	14	8
Occupation Estimate	i	-	6
	ii	-	9
	iii	-	11
	iv	-	9
	v	-	6
Discharged	-	28	6

Comments

(1) The 28 people discharged were all deemed ineducable and were removed from school before the normal leaving age. It was expected that most would need hospital care.

(2) The figures in the "For Comparison" column were obtained by calculating the incidence of handicaps in a hypothetical average group of 41 subjects of the whole research group of 314 people. As would have been expected, compared with the average, the frequency and severity of intellectual and behaviour handicaps is much more marked in the hospital group. The comparatively high incidence of deaf-blindness and epilepsy is also to be expected.

(3) There is great similarity between the two groups as far as sex distribution, visual handicaps and physical handicaps are concerned.

This isolation of single handicaps has some importance, but we are more interested in the whole personalities of multi-handicapped people and, in particular, why they are in hospital, plus the possibility that some of them should not be there. To assess accurately such an entity as a "whole personality" is impossible, but an examination of each person's combination of handicaps plus my own assessment of the individual's personality, even though it is subjective, should help to make a fairly useful estimate. Let us consider first those of our

41 subjects who appear to need the services which hospitals provide. I emphasise that I have carried out the rather detailed examination of individuals which follows as objectively as possible and did not consciously set out to justify any previously known lists of selections of people for retention in hospital or transfer.

People Probably Correctly Placed in Hospital

The two handicaps which indicate the probable need for hospitalisation are severe intellectual handicap (C), and severe behaviour disorders (M). Thirty-one ex-Condover hospital residents have either one or both of these severe handicaps and their cases are considered in the next four paragraphs. I give one case description at the end of each paragraph. The number at the end of each case indicates the person's position in Table 3.IV.

1. Fourteen people have both of these conditions, (C) and (M)

i Seven are men and seven are women.
ii Two are partially sighted, four are partially blind, and eight are blind.
iii Five are classified as deaf-blind.
iv Six have epilepsy.
v One has physical handicaps (a), one has physical handicaps (c).
vi Seven have medical histories possibly indicating brain damage.

Mr. E.Q., aged 23. As well as having very severe intellectual and behaviour handicaps, E is deaf-blind. His blindness is total and his deafness, though not total, is of that 'central' type which prevents the understanding and expression of speech. At school, where he stayed six years from the age of three, he had a habit of hitting himself, which we were unable to curb. As a man, this habit continues and he is liable to cause himself considerable damage so that quite forcible restraint has to be used at times. He now responds to three or four simple one-word spoken commands, but erratically. He enjoys accompanied walks in the hospital grounds but, apart from this, he successfully resists efforts to get him to do anything. He is epileptic. (OC)

2. Five people are classified as Deaf-Blind with intellectual handicap (C), though they are not ranked as (M) for behaviour disorders.

i All five are women.
ii Two are partially blind, three are blind.
iii One has remained so immature that a score for behaviour disorders is inappropriate. She has physical handicaps grade (c).
iv Although three have developed a little more than the woman in (iii), they
v are still very immature. They are classed (m) for behaviour disorders. One has a physical handicap (b).
v The fifth, the youngest of the whole hospitalised group, is very withdrawn. It is possible that she may improve but hospital placement is best for her now.
vi Three have medical histories possibly indicating brain damage.

N.B. All the 10 deaf-blind people (five in paragraph 1 and five in paragraph 2) have no real method of communication. For seven of these the cause of the visual-aural handicap is the mother's rubella during pregnancy.

Miss I.D., aged 23, is deaf-blind. She has no sight and her hearing is very slight. She was admitted to Condover at the age of seventeen months and stayed for eight years. When she left school her accomplishments were approximately equivalent to that of a twelve-month old child and they are still at that level. She is

completely incontinent and needs complete help with dressing, eating, etc. She can walk with someone supporting her, she responds with a smile to a rubbing of her arm, and she rarely, if ever, shows signs of distress. (OB).

Seven other people with severe behaviour disorders (M) who do not have the most severe intellectual handicap (C)

i Four are men and three are women.
ii Four are partially blind and three are blind.
iii Six are classed as (B) for intellectual handicap and the other one as (A).
iv In four there is a considerable element of aggression in their behaviour disorders. One of the four is epileptic.
v Three have patterns which can be described as very strange, rather than aggressive. One man suffers from diabetes which is becoming increasingly difficult to control and has what his consultant describes as "severe personality disorders". A second man's behaviour switches erratically from rational to irrational. He is epileptic and has a physical handicap grade (a).
vi Two have medical histories indicating possible brain damage.

Mr. U.D., aged 25, who is partially blind, was a rather passive boy at school, rather timid but with occasional, unexpected obstinacy. Some years ago, while at home, he began to have epileptic fits and his behaviour became increasingly difficult. He was admitted to hospital where, when in the mood, he will do some simple craft work. He has aggressive outbursts, which I experienced when I saw him at hospital with his mother. U. suddenly attacked his mother, apparently because she had forgotten to bring him a small model car. I found restraining him rather difficult and his mother received facial bruises and scratches. (7B).

Five people of severe intellectual impairment (C).

i All five are men.
iiii One is partially sighted, two are partially blind, and two are blind.
iii One is of very low intellectual and practical ability.
iv One has some verbal facility but very poor practical ability.
v Two are epileptic and have severe physical handicaps - one of grade (b) and one of grade (C).
vi Two have medical histories indicating possible brain damage.

Mr. E.N., aged 29, was partially sighted at school but is now totally blind. He seems to have adapted quite well to his blindness and is independently mobile in the ward and its immediate neighbourhood. Pressures of time and staff shortage prevent him practising the minor skills of self-care, of which I feel sure he is capable. His conversation is limited but in his gruff way he enjoys a simple joke. He can be unco-operative and does not respond readily to the activities of the special centre for blind patients which he attends occasionally. (7E).

Mr. N.K., the partially sighted person among this group of five, is recommended by his consultant for promotion from hospital and, to me, this seems justified. The other four need hospital care and this gives a total of 30 people who are suitably placed in hospitals.

Discussion of Mental Handicap

Some of these people's handicaps merge one into another and my analysis according to handicaps is somewhat artificial. I have approached the problem from the point of view of an educator, but I realise that essentially I am fairly close

to the working of the Mental Health Act of 1959 in my use of categories B and C in intellectual handicap. Using the Act's definition of 'severe subnormality' these 30 people would be severely subnormal because they have such an incomplete development of mind, including subnormality of intelligence, that they are incapable of living an independent life or guarding themselves against serious exploitation'. To me this is a correct description of the 30, but it does not fit Mr. N.K. and the other 10 Condover ex-pupils with whom I shall shortly deal. I shall continue to use my analysis based on handicaps but this time I shall be approximating to the medico-legal definition of 'subnormality'. Again using the phraseology of the Act:- 'have these people an incomplete development of mind, including subnormality of intelligence (not amounting to severe subnormality) that is susceptible to medical treatment, special care or training?". To which I add - 'which can lead to a fairly independent life outside hospital?'.

I should point out that the terms 'mental handicap' and 'severe mental handicap' seem to be replacing the descriptions 'subnormality' and 'severe subnormality' though there are no changes in fundamental definition. There is one other type of disability defined by the Act, that of 'psychopathic disorder', i.e. 'a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment'. There is certainly some similarity between this definition and my description of severe behaviour handicap.

One Special Case for Consideration for Transfer

Mr. N.K. is now aged 26 and has been in hospital for more than six years. Although he is rated as (C) for intellectual handicap he is near the borderline with (B) and he talks fairly rationally with reasonably good common sense. His physical handicaps - ranked (b) - affect his legs more than his arms and he makes fairly effective use of his hands. His sight, though defective, is really quite good, well within the range of partial sight. Difficulties at home, mainly because of his lack of occupation, contributed to his admission to hospital. He has made good progress at his hospital which is of a reasonably small size with the benefits which this can produce. It so happens that, within two miles of his home, there is now an Adult Training Centre for the Mentally Handicapped with an associated hostel. I think it would be well worthwhile giving Mr. N.K. a trial at this A.T.C. (18A)*.

Two Special Cases for Retention

Two other people among the 31 were considered by the consultants to be suitable for transfer, but I think they should be retained in hospital, since they appear to be definitely severely subnormal.

Mr. K.Q. is now aged 26 and has, according to my rating, the two very serious handicaps (C) and (M). He has almost no experience of life outside hospital. (15B).

Miss T.D., now aged 20, is the most advanced in self-care of the deaf-blind group, but she presents great difficulties when a less sheltered life than that in hospital is considered. She has no effective communication, her behaviour is somewhat bizarre and she would need more staff care than it is reasonable to provide outside hospital. (13C) .

* *The bracketed numbers (18A) etc. refer to an individual's position in Table 3.IV, page 56.*

People for Consideration for Transfer

For comparison and reminder I give here a development of Table 3.I, dividing the whole group of 41 into (a) 30 people who need hospital care and (b) 11 candidates for transfer, i.e. 10 people whose cases have still to be discussed plus Mr. N.K.

Table 3.II Suggestions for Retention and Transfer (N=41).

		Total (41)	For Retention (30)	For Transfer (11)
Sex	M	23	15	8
	F	18	15	3
Vision	PS	8	2	6
	PB	15	13	3
	B	18	15	2
Intellectual Handicap	Nil	0	0	0
	A	4	1	3
	B	13	6	7
	C	24	23	1
Physical Handicap	Nil	31	22	9
	a	2	1	1
	b	5	4	1
	c	3	3	0
Behaviour Handicap	Nil	12	5	7
	m	8	4	4
	M	21	21	0
Deafness	Nil	31	20	11
	d	0	0	0
	D/B	10	10	0
Epilepsy	-	14	9	5
Occupation Estimate	i	0	0	0
	ii	1	0	0
	iii	7	1	9
	iv	9	7	2
	v	24	22	0
Discharged	-	28	25	3

Comments

(1) Let us consider the 11 people for transfer. The totals for the handicaps indicate clearly why these people are suitable. On the whole they have more sight and intelligence than the other people in the hospital group. The group contains only one person with a physical handicap and no-one with a severe behaviour handicap. There are only two people with medical histories indicating possible brain damage.

(2) There is one surprising factor which prompted me to seek further information from the hospitals - the number of epileptic people for transfer is higher than I would have expected. I find that of the five people listed, one is in an Epileptic Colony, two have fairly frequent attacks of petit mal while for the other two people, complete control through medication appears to have been achieved.

(3) Occupation Estimates. I consider that one person estimated to be in category (ii) at leaving school now functions at level (iii), two people have improved from (v) to (iv) and two from (iv) to (iii).

Independence in Self-care

If people are to be transferred from hospital to live in less sheltered conditions with much less staff supervision it is important that they should be as self-sufficient and independent as possible. Apart from the comparatively minor severity of handicaps, other important factors are practical ability, independence in self-care, leisure-time interests and some preparation for life outside hospital. From the questionnaires completed by members of the hospital staffs working closely with former Condover pupils I have gathered some important information on some of these topics, in particular on self-care. At school we paid much attention to pupils' training in the skills in self-care and this group of skills is probably the most relevant factor when we are considering possible transfers from hospital.

In the questionnaire I selected seven areas of skill (dressing, care of clothes, washing, bathing, toilet, bed-making, feeding) and asked the staff to score the individual concerned at one of the following four levels of attainment:-

(a) completely independent; (b) needs a little help;
(c) needs much help; (d) completely dependent.

I have details for 39 subjects, questionnaires for the other two people not having been returned. The two about whom I have no questionnaire information have been classified for retention in hospital, as I know that they are very dependent.

The 4-point scoring scale of (a) to (d) provides a continuum from complete independence to complete dependence along a scale of increasing need for help. I have therefore converted the graded scale of four stages to a numerical scale by awarding scores thus: completely independent:- 3; needs a little help:- 2; needs much help:- 1; completely dependent:- 0. The total score for each individual, taking into account the seven areas of skill, is placed somewhere in the range 0-21.

Since we are considering the topic of retention-transfer I give these figures:-

Table 3.III Hospital Staff Estimates of Independence in Self-care.

	N	Total	Average	Range
Complete Group	39	407	10.4	0-21
For Retention	28	223	8.0	0-19
For Transfer	11	184	16.7	10-21

When the numerical scores are re-converted into the four-point scale, the following interesting information emerges:-

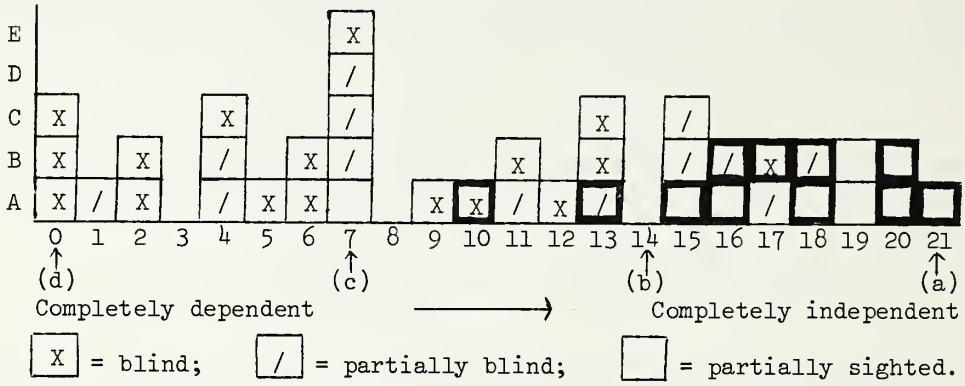
i for the retention group the mean score of 8.0 is just above (c) (which is equivalent to a score of 7) and indicates a self-care skill of "needing much help";

ii for the whole group the mean of 10.4 is almost exactly mid-way between (c) and (b), i.e. between "needing a little help" and "needing much help";

iii for the transfer group the mean score of 16.7 lies two-fifths of the way from (b), "needing a little help" to (a), "completely independent".

Individuals' self-care scores are shown in the following histogram, which also shows visual handicaps. Each cell represents an individual, the squares with darker perimeters indicating the people suggested for transfer. The letters A to E are aids to identifying individuals, e.g. Mr. N.K. is represented by square (18A).

Table 3.IV Self-care Scores — Visual Handicap, Transfer and Retention. (N=39, two questionnaires not returned).



Comments

(1) Apart from the people represented by (10A) and (13A), all the people for promotion scored 15 or more. Five people who scored 15 or more and are not recommended for promotion have severe additional handicaps which, using the usual scoring code, are:-

(15B): Miss E.D. aged 35, intellectual (C), behaviour (M) and epilepsy.
(15C): Mr. K.Q. aged 26, intellectual (C), behaviour (M).
(17A): Miss S.D. aged 34, intellectual (B), behaviour (M).
(19A): Mr. I.P. aged 37, intellectual (C), behaviour (M) and epilepsy.
(19B): Miss B.T. aged 34, intellectual (B), behaviour (M) and epilepsy.

(2) The table demonstrates the low abilities of the blind subjects and, to a lesser extent, of the partially blind, compared with the partially sighted. The question can be asked: to what extent is this due to the blindness itself? In my opinion the lack of ability is due to the overall condition of multiple handicap in which blindness is only one factor. Nevertheless every effort should be made to ensure that the effects of blindness are minimised and I emphasise this fact strongly later and feature it in my list of recommendations at the end of the chapter.

People for Consideration for Transfer: Case Descriptions

In the following four sections I discuss the individual people in more detail. The figure in brackets after each person's description indicates the cell which will identify him or her in Table 3.IV.

Three Partially Sighted Men with Intellectual Handicaps (A) or (B) but with No Other Serious Handicaps

Mr. R.B., now aged 41, has been in hospital for 24 years and remains rational and self-responsible. He has had the benefit of living in a small hospital in a

country town with some staff who have worked in the hospital for many years. Although the buildings are far from modern, the units are reasonably small, the staffing is adequate in number and geared more to domestic living for the patients than to institutional life. (20A).

Mr. E.Y., now aged 37, has lived in a larger hospital for 16 years with fewer opportunities for domestic-scale living but with some specially advantageous features for him. He attends the hospital's occupation centre daily where one of the staff was formerly a craft instructor for the blind. In addition he has been able to join in some of the social activities of the Welfare for the Blind section of the Social Services Department. Mr. E.Y. attends church services outside hospital. (21A).

Mr. O.M. now aged 26, has been in hospital for four years since his parents decided that living at home was unsuitable for the social life of the rest of the family. They also felt that this situation was unsuitable for their partially sighted, pleasant, educationally subnormal son - I rate him in Category (A) - intellectual handicap - who had no occupation and little contact with people of his own intellectual level in spite of considerable efforts to find suitable opportunities for him. His parents refused to co-operate with my research. (16A).

Two Partially Sighted People with Intellectual Handicaps (A) or (B) and with Grade (M) for Behaviour Handicaps at School

These two people, one man and one woman, were both considered, at school leaving age, to have so acute a behaviour disorder, that they needed hospital treatment. While they have been in hospital they have improved considerably.

Mr. F.M., now aged 30, lived in a very large hospital for 12 years. About two years ago he was moved to a smaller establishment still under the aegis of a Regional Hospital Board. He lives in a hostel for about 40 men and there are two other hostels in the same facility. This is a half-way residential establishment between a large hospital and a hostel in the community. The residents attend daily the establishment's occupation centre which has many similarities to an A.T.C. Mr. F.M. works fairly well in the occupation centre. In social affairs he is rather solitary, but he makes full use of the freedom of movement which he is allowed. He travels independently for some miles around the 'hospital', using buses and cafes and doing simple shopping. (20B).

Miss N.U., now aged 24, has been in hospital for nearly 10 years. She has improved in behaviour much more than I would have expected. Although I still class her as (m) for behaviour, she is much more controlled than she was at school. I rate her intelligence as category (A). The hospital has a well appointed Social Centre for its residents and a flourishing occupation centre. Miss N.U. takes an active part in both these activities. In addition the Blind Welfare section of the local Social Services Department has given her opportunities to attend classes and social functions outside the hospital. (15A).

Three Partially Blind Men with Intellectual Handicap (A) or (B), with Active Epilepsy

The epilepsy plus family circumstances were the deciding factors in the admission of these three men to hospital. The circumstances surrounding each case are very different.

Mr. K.V., now aged 41, who at one time attended a day occupation centre, became unable to do so because of the onset of epilepsy and subsequent increase

in its frequency and severity. He lived in the house of one of his sisters who is a widow. As the sister went out to work and had to run the house as well, K. had to be cared for mostly by his frail old mother. The death of the mother brought matters to a crisis and Mr. K.V. was admitted to a hospital for the mentally handicapped. He is backward, slow in speech and in movement but is essentially rational and makes sensible contributions to fairly simple conversation. The hospital consultant considers that K. would manage in a local authority hostel. His epilepsy is now fairly well controlled. (13A).

Mr. S.T., aged 22, is rated as (A) for intellectual handicap but is also physically handicapped in category (a). Although the physical handicap is not severe, it increases S's tendency to fall when he has one of his fairly frequent epileptic fits. His physical care became increasingly difficult at home and the situation was made more unsuitable by the lack of contact with people of his own age. He became bored and 'difficult'. He is now in an epileptic 'colony' with reasonably pleasant accommodation, opportunities for simple occupation, sympathetic staff, and some companionship from other residents. The young man is quite happy, his parents pay frequent visits and have him at home for holidays. The medical consultant thought S. could be transferred elsewhere, but when I discussed the matter with her she agreed that, under the circumstances, which I have outlined above, his present placement is satisfactory. He is, of course, not really in hospital, though his establishment has some of the features of one. (18B).

Mr. Q.D., now aged 29, was admitted to hospital for a mixture of reasons:- the lack of availability of a day centre near his home, the combination of his visual and intellectual handicaps complicated by his epilepsy, and the desire of his parents to find a haven for their son when they can no longer cope. His father is now aged 71 and his mother is a few years younger. Mr. Q.D. passes most weekends at home. The consultant feels that there is a danger of Q. becoming institutionalised and feels that he could manage in a "very sheltered hostel" if such a facility became available - which is not likely in the near future. (16B).

Two Blind Women with Intellectual Handicap (B) and Grade (m) for Maladjustment

These two women are the only two totally blind people suggested for transfer.

Miss R.Y, is now aged 35. She was admitted to hospital after the death of both her parents. She has a history of severe epilepsy which the hospital states is now under control. She is very verbal and not very practical. In behaviour she tends to be impulsive and rather easily emotional. Her conversation is usually at a much higher level than most of the residents in hospital. (10A).

Miss R.P., is now aged 29. After unsuccessful efforts to find their daughter a placement for occupation, Miss R.P.'s parents have managed to find her a in a hospital. She spends all week-ends (and some holidays) at home. R. is a pleasant young woman with very acceptable social conversation and graces. Her emotional handicap is one of the least severe in the ranking of (m) and is mainly a matter of immaturity. She is moderately intellectually handicapped, probably nearly (A) though I have rated her as (B), and she lives among many severely intellectually handicapped women. This could appear to be an unfortunate situation but when I asked R. how she enjoyed being at hospital, she replied "It's lovely!". This was in a private conversation when the atmosphere was such that she could express a real opinion and not a polite, social response. (17B).

N.B. Mr. N.K., originally included in the retention group, has been firmly recommended for consideration for promotion.

A Summary: My Personal Assessments

I give now my own assessments based on the information already given, and on my personal contacts with, and knowledge of, each individual, with some indications of their "readiness" to live outside the sheltered conditions of hospital life. I have also given some weight to the availability of suitable accommodation in the foreseeable future. The people for transfer are listed in two groups:-

High Priority It is a matter of considerable urgency that seven people should be promoted as soon as possible. They all have useful sight and could live with only a little supervision in a hostel for mentally handicapped adults and attend an A.T.C.

(a) Messrs. R.B., E.Y. and O.M. are exceptionally good candidates for promotion. They have pleasant temperaments, are rational and co-operative in behaviour and have had reasonably good contacts with society outside hospital. They would not present problems in the use of leisure time.

(b) Mr. F.M. now lives in hostel conditions on the hospital side of the fence, as it were. He has similar abilities and experience to the first three men, but has a somewhat more difficult temperament. Successful placement in the community would be a success for the acclimatisation process which is one of the functions of the hospital hostel. It is highly desirable that there should be a flow of hospital residents through the hospital-hostel to hostels in the community.

(c) Mr. K.V. has only been in hospital for a year. His epilepsy has been controlled and further hospital treatment is unnecessary. The hospital should not be expected to retain Mr. K.V. indefinitely. The treatment he has received should be considered as rehabilitation for sheltered life in the community.

(d) Miss N.V. The staffs of hospital and of Social Services have both contributed to this woman's improvement. Transfer to a hostel in the community would be a happy outcome of this co-operation not only as a personal benefit for Miss N.V., but also as a reward for staff effort.

(e) Mr. N.K. The actual facilities are in existence. All that is needed is a definite placement, but the queue is long!

Lower Priority The present conditions for the four people in this group are fairly satisfactory. The family crisis situation has been solved. It would not be realistic to recommend them for placement in the present hostel-A.T.C. situation - even if it existed - since they would require too much care and supervision from staff, particularly in the hostel. Alternative, more sheltered accommodation does not yet exist and there appears to be none even in the long-distance planning phase.

(a) Miss R.P. and Mr. Q.D., who have good community contacts through their families, would certainly profit from some fairly sheltered hostel life. At present this is not a realistic possibility. Perhaps this type of facility should be provided in the hospital situation and be consciously aimed towards community contacts?

(b) Mr. S.T. is satisfied with his life in an Epileptic Colony where the villa accommodation is reasonably comfortable and occupation possibilities exist. The staff are prepared to retain him. He has frequent contacts with his parents.

(c) Miss R.Y. has poor self-care achievements. Her parents retired from Lancashire to the South Coast. The parents have died and R's only relatives - and they are very interested in her - live in Lancashire. I would like to see this woman transferred to the hospital in Lancashire which has its own centre for the Blind and which is discussed later in this chapter.

Miscellaneous Statistics

Occupation The hospital staff questionnaire included three sections concerning this topic. All hospitals had some sort of occupation centre, though the titles varied. For simplicity I will refer to organised occupational activities as Occupational Therapy. In some hospitals, the residents are encouraged to help staff with a variety of tasks. Although all such tasks do not take place on the actual wards, it is convenient to refer to this type of occupation as Help to Staff on the Wards.

(a) Occupational Therapy Units Staff were asked to underline the appropriate comment concerning our former pupils, which gave the following statistics:-

Total replies - 38; Very effective work - 3; Mildly effective work - 17; None - 18.

The work varied from simple craft work to the packing and assembly work often a feature of the Adult Training Centres for Mentally Handicapped Adults.

(b) Help to Staff on the Wards This was dealt with in a similar way to the Occupational Therapy and gave the following figures:-

Total replies - 38; Very effective help - 2; Mildly effective help - 12. None - 24.

The very effective help given by two people was assistance and some responsibility with ward linen by one man and helping the staff with the most handicapped people on the ward by a woman. The mildly effective help tended to be with household tasks on an occasional basis rather than a planned rota scheme.

(c) Other "Work" In addition, staff were asked to describe any other work which was undertaken by the subjects of the research. There were 38 replies, of which 31 were "none". Of the other seven people, there was one reference to a man who is a reliable messenger and another reference to a woman who does some effective knitting with strong nylon. Otherwise the other five references only repeated either occupational therapy or ward help activities.

Comments

(1) Although the amount of occupation is very small, many former Condover pupils in hospital are of extremely low ability.

(2) Staff shortages and understaffing mean that work on the wards tends to be hurried. Timetables have to be maintained. Any help from residents tends to be encouraged but comes from only the most able. Opportunities for help activities which would be of benefit to some visually handicapped residents simply cannot be provided under present circumstances.

Leisure Time

(a) Staff were asked to describe the subjects' principal activities and interests. Thirty-eight replies were received and a great variety of topics were mentioned. These can be summarised thus:-

passive listening - 24 (music, radio, T.V., records);
organised activities - 16 (social, dancing, cinema, music);
conversation was noted 5 times;
personal interests involving activity - 19 (5 mentions of walking;
2 mentions each of crafts, tape recording, reading and church;
1 mention each of melodica, piano, skittles, parole and religion);
miscellaneous - 6 (none; noises; twiddling; playing with texture;
peering at bright objects; 3 baths per day).

(b) Staff were asked to indicate the frequency with which these interests took people away from the hospital with the following results:-

Total replies - 38; Regularly - 6; Occasionally - 7; Never - 25.

The activities taking six people regularly away from hospital were, for four people, social and other activities organised by blind welfare; for two people, regular attendance at church services and meetings.

No information was provided about four people who are occasionally away from hospital but one of these goes home frequently for weekends. Church activities accounted for two people being away from hospital, while a mixture of trips, much more varied than the usual hospital organised events, took the other person away.

Comments

For the people who do not attend occupational classes, the leisure time activities fill most of the day. For the least capable, it is difficult to think of other realistic activities which could be provided. The most capable, who attend occupational classes, also have the more interesting leisure programmes. I think that the lives of people in the middle range of ability, about one third of the total, could profit from a better developed programme of leisure activities.

Visitors and Holidays

(a) Visitors Staff were asked to name each subject's visitors and to give the approximate frequency of the visits. As suggestions for expressing frequency I mentioned "weekly, monthly, twice a year, etc.". I received replies concerning 38 people. In one other case the information was not complete so I have not included it in the statistics below:-

Number of replies - 38;
weekly visits : relatives - 9; church visitor - 1;
fortnightly : relatives - 3;
once per 3 or 4 weeks : relatives - 7; "friend of the hospital"- 1;
once per 2 months : relatives - 5;
once per 3 months : relatives - 1;
twice per year : relatives - 4;
once per year : relatives - 1;
no visitors for over 1 year - 3; over 2 years - 1; never - 3.

Comments

(1) The number of frequencies above totals 39 but concerns only 38 people. The explanation is that one man who receives a monthly visit from his father also has a weekly church visitor.

(2) Only one "friend of the hospital" is involved in visiting and this is part of the rehabilitation programme for Miss N.U., one of the promotable people.

(3) The table of frequency of visits reveals that 18 people receive less than one visit a month, but four of these go home for at least two weeks per year and three others, who are in the "promotable" list, live a reasonably full life devised by the hospital. Ten people with infrequent or no visits have either severe behaviour problems or almost complete lack of communication, so that visits have considerable elements of embarrassment or distress to the visitors, with very little benefit for the patients.

(b) Holidays Staff were asked to give information about the subjects' holidays at their own homes, with the following results:-

number of replies - 38;
no holidays - 26 (but one person pays frequent day visits to relatives);
two days per year only - 1;
occasional holidays of the order of two weeks per year - 6;
more frequent than this - 4;
every week-end plus some longer holidays - 1.

Information was also given about holidays arranged by the hospitals for groups of patients. These holidays varied in length from one to two weeks per year. Six ex-Condover pupils profited from this service, including two who also have holidays at home and four who do not.

Comment

The situation is so complicated that I feel unable to make any helpful comments, except I am left with a vague feeling of distress about the large number of people who get no holidays. However, most of them are so severely handicapped that they would probably not profit from them.

Liaison with Social Service Departments

In 1974 Local Authority Social Service Departments took over responsibility for Hospital Social Workers. It is hoped that this will help to improve some of the situations described below.

The consultants were asked if there is liaison between their hospital authority and Social Service Departments. Thirty-three replies were received, 28 reporting YES and five NO. The five people who reported 'no liaison' all said it would be welcome.

The consultants were further asked if individual Condover ex-pupils received help from a Social Welfare Officer for the Blind, or someone with specialised training or experience with blind people. They were also asked to state what form this help takes. If no help is received, the consultants were asked to state if they think it would be helpful. In addition, hospital ward staff dealing with Condover ex-pupils were asked if these people receive help from a S.W.O.B. The information received is summarised thus:-

i Replies from consultants:- total - 33, concerning 37 ex-pupils - help received : Yes - 11; No - 26.

ii Answers concerning the 26 people who receive no help and the possibility of its usefulness if it were available were:- Yes - 14; No - 4. There were also indefinite replies from some people, i.e. Probably - 2; Possibly - 2; Doubtful - 1. For three people the question was not answered.

iii The type of help received can be summarised as:- Regular visits plus outings - 6 (one of these people accepts the visits but refuses all outings); Occasional visits - 4; Gifts only - 1. The outings referred to are handwork classes and social events with non-hospitalised blind people.

iv Replies from hospital ward staff:- Total - 38; Help received : Yes - 7; No - 31.

Comparison of (i) and (iv) shows that while the consultants considered that 11 individuals are receiving help, the ward staff considered that only seven were doing so. Apart from one case the discrepancy is unimportant since it concerns only the occasional visits mentioned in (iii) and these appear to have been widely spaced routine visits.

My enquiry dealt with ex-Condover people only and did not concern the much larger number of blind people in hospital. There is no reason to suppose that the Condover people are special cases and I am convinced that there is a great lack of specialised help for all blind people in hospital. Nevertheless, the situation should be considered dispassionately and I make the following three points:-

(1) Although more blind people could profit from special treatment, there are many blind people in hospital whose blindness is only one of several severe handicaps and is of no special importance.

(2) The Social Services are already working under considerable stress with lack of money and trained staff.

(3) For many hospitalised blind people, staff experience and training with people suffering from mental handicap or illness is just as important as experience and training with the needs of blind people.

A Blind Unit within a Hospital

In many hospitals the staff, who would like help and guidance from people with experience and training with the blind, have been unable to find such assistance. I was, therefore, very interested to come across a new and encouraging development. I will use a description of this development and also, a detailed case study of the only Condover ex-pupil who has been promoted,as practical examples of some of the points I shall make in the Summary and Recommendations section which ends the chapter.

At one hospital, Calderstones at Whalley in Lancashire, the staff took the bold step of establishing in October 1972 an Occupation and Social Unit for Blind Patients within the hospital. A year after the opening of the Blind Unit I was invited to spend three days there to observe the work and offer advice. I was pleased to accept since I feel that the Calderstones' staff are making a very important contribution to the welfare of blind people in hospital and that other Hospital Blind Units could well be formed elsewhere. My visit ended with a Unit Staff Meeting at which I presented an informal report, the main points of which were:-

i the development of a programme of personal independence including such items as dressing, personal cleanliness, bed-making and mobility;

ii the development of a scheme of simple homecraft within the Unit, which could help with some of the items in (i) and would also provide experience in simple cooking and housework;

iii an increase in integration of visually handicapped people into the hospital's Industrial Therapy Centre's activities by practising some of the work skills of the Centre within the Blind Unit and by placing appropriate blind people in the Centre.

In addition, I put this question to the staff:- Could there be some re-grouping of blind people, who are now scattered in units throughout the hospital, so that groups of five or six blind people could be assembled in wards which would still have seeing patients too? I am of the opinion that the setting up of completely "Blind Wards" is not advisable.

I was conscious of my own lack of experience with severely mentally handicapped adults and with hospital procedures. Also I was aware that my suggestions were too vague. However, incidental conversations with individual members of staff and then the final discussions of the staff meeting led to much more practical suggestions listed below:-

Involvement of Ward Staff This is very important in the living situation, especially in such matters as personal hygiene, feeding, and dressing. It was suggested that the Blind Unit Staff could undertake this kind of training jointly with the Ward Staff.

Homecraft Apart from the enjoyment to be gained from a homecraft scheme, there is the usefulness of any skills acquired, together with the natural, realistic development of other senses than sight or the effective use of small amounts of residual vision. Senior Staff stated that a room adjacent to the Blind Unit could be used as a homecraft room.

Mobility Training Since it is unlikely that the services of a trained Mobility Officer for the Blind will be available in the foreseeable future, the staff should develop their own scheme based on the training of each individual's essential movements about the hospital. The residents' own wards would be the bases for this programme but training exercises could be carried out in quiet areas of the hospital grounds and in appropriate covered areas for improving confidence in walking and where the detection of objects and the avoidance of obstacles would be practised.

Visits outside the Hospital Some visits already take place but with little planning. The scheme needs extension with the development of a rota of excursions, having the special needs of blind people in mind. The visits should be planned and discussed with the residents before the visits with follow-up discussions afterwards.

Holidays The staff suggested an experimental holiday for the blind should be planned with a small group with a view to further expansion if this proved successful.

Gardening This could prove to be of practical and therapeutic value. The difficulties experienced by blind people in gardening can be overcome by carrying out activities on a small scale. Flower and vegetable plots should be of such small size that gardening and the inspection of growing plants can be carried out without any walking on the cultivated ground being necessary. Small raised plots and even soil placed in the centre of old tractor tyres have been found useful.

Tape Recorders These can be very useful. Taped letters and messages could be exchanged and passed round the Unit and the Hospital. Recordings can be made of sounds heard in the countryside and in the community, including recordings made during visits outside the hospital. Some simple teaching tapes involving "learning by listening" could be made by staff plus recorded stories and simple plays. If any person shows signs of profiting from learning braille, Dr. Tobin's scheme of programmed learning, using a tape recorder, to help with learning of the early stages of braille reading, might prove useful.

Music The Unit could profit from blind people's special interest in music by planning musical activities. A piano would be very useful - as would the help of some member of staff, or a volunteer, able to play it.

Swimming Selected blind people could be given the opportunity of trying to learn to swim, perhaps first in the hospital's remedial pool.

Group Discussions Involving members of the Unit in meaningful discussions could become an important feature. Many of the Unit's activities have important possibilities for the development of vocabulary, and discussions would serve to emphasise the good use of language and memory as well as orderly behaviour in a formal group.

Six months after my first visit, I went to the Blind Unit again and found that the staff had extended their activities. Ten "low dependency" patients attend five days per week while 26 "high dependency" patients attend twice per week. I was interested to note that some of the recommendations of the staff meeting, which are listed above, were being carried out, viz. a homecraft centre has been started, mobility training is taking place, some use of a tape recorder has been tried. There is some co-operative action between Unit and Ward Staffs, though I think that this could be developed further. A piano has been acquired, but it needs tuning. My main concern is that the staff should work quickly through the period of uncertainty which is bound to affect people who are undertaking pioneering work and realise their lack of training and experience. No appropriate courses of training are yet available for hospital staff dealing with blind people so it leaves the staff to undertake their own training. I suggest that this could best be based on a programme assessment and case studies described below.

Assessment and Case Studies

The hospital is carrying out a large-scale assessment programme of all its 1,450 patients. I think assessments of blind people should be carried out at regular intervals on a staff-meeting/discussion basis in the Unit. This could involve Ward staff responsible for blind individuals and the staff of the hospital's Social Therapy Department. Special exercises could be used for estimating blind people's vision in action or its replacement by the use of other senses. Nothing elaborate in the way of apparatus is needed; the essential element is that staff should observe the blind people in action, manipulating known and unknown simple apparatus and utensils, e.g. pegging, lacing, pouring liquids, cutting, etc. Exercises in simple mobility can be carried out. These test-cum-exercise activities would be useful in helping staff to realise the problems - and the abilities - of visually handicapped people. The assessments would be concerned with social and practical matters, with estimates of independence, use of language, hearing, touch, etc. Since there are no sources of ready-made tests, record cards, and scoring schemes, it is a challenge to the staff to devise their own. If possible, each blind person's progress should be reviewed twice yearly. This could lead to short-term objectives for individuals with fairly frequent report-back. Such a programme as I have vaguely outlined needs to be realised in the

actual terms of the staff and the facilities available and the qualities and abilities of the blind people themselves. In carrying out such procedures the staff are carrying out informal in-service training. The assessment and experimental activities need not be too time-consuming but would be a spur to the development and variation of the Unit's programme.

The One Successful Rehabilitation of a Hospitalized Condover Ex-pupil

It so happens that, in the terminology of the Mental Health Act, the young man whose case study I now present suffered from a psychopathic disorder rather than subnormality.

Mr. L.G., who is now aged 23, came to Condover at the age of nine with a well-established reputation of being a very difficult child. He had been abandoned shortly after birth and taken into Care by a Local Authority. He attended a Sunshine Home two hundred miles away from his Local Authority, moved to another Sunshine Home and then to Condover, all being more than a hundred miles from the foster home which was found for him. He was a very difficult proposition at home but the original foster parents, and, later, their own son and his wife, persevered. Even now, they take L. for occasional short holidays.

Intelligence tests at school indicated that L."s intelligence was within the normal range, with an I.Q. in the 90's. He did not use this intelligence in any official education programme. He only has a minimal amount of vision and, in my classification, I rate him as blind. He was always exceptionally good in mobility. He was obsessively interested in clocks, radios, plumbing arrangements etc., being remarkably adept in the use of his hands in dismantling these things. His expressed desire to re-assemble them was never realised. In many ways he was very good in overcoming the problems of his blindness but rarely did he use his abilities in a constructive fashion. L. was an ingenious provoker of other children — and staff, too — and was very aggressive at times. Nevertheless he always had a few friends and 'defending counsels' among the staff.

After three years at Condover, L. went for psychiatric treatment for six months at Maudsley Hospital. His Local Authority was now taking more interest in him and our recommendation was that, if his treatment were successful, he should be found a school placement in a school for normal blind children and some sort of long-term 'home' placement. We felt that he should not return to Condover. At the time of L.'s discharge from hospital the Local Authority could find neither home nor school placement, so we re-admitted him as a temporary measure. Unfortunately his behaviour showed no improvement, in fact he was more irresponsible and aggressive so, finally, when he was 14 years old, we asked for him to be removed from school. We learned that he had been found a home at Fulbourn Hospital for the Mentally Handicapped.

Fortunately L.'s progress has taken a turn for the better. My letter to his Consultant Psychiatrist seeking permission to visit L. as part of my research survey, elicited a lengthy reply to the effect that I could come, and what could I suggest as a placement for L. outside hospital? Were there really no specialised facilities for the blind where he could be placed? I had to reply that I knew of no such places and rather forlornly suggested that if L. really was fit to live outside hospital perhaps he could be integrated into some facility for seeing people.

I could not believe that L. could have improved greatly, but I was wrong. On my visit to Fulbourn I found a much improved person with only mild traces of his previous difficulties and I found myself sharing the hospital staff's frustration that nowhere could be found for L. to live outside hospital. Fortunately

six months later he was admitted to the Local Authority's newly opened Day Centre for the Physically Handicapped and was living in the Hostel associated with the Centre. I have had the pleasure of visiting L. there, where he has settled down well, being much helped by the attitude of the staff which is a mixture of compassion and warm affection allied to a firm desire that L. should succeed — which means some forceful urging at times.

What were the factors which contributed to L.'s successful promotion? There was the Consultant Psychiatrist's personal interest in the project; the Ward Sister's warmth and affection plus some demands on L. for co-operative behaviour; the Librarian's voluntary help in finding him an odd corner where he could practise typewriting; the Occupational Therapy Staff supplied practical work; the Local Authority's Social Welfare Officer taught L. braille so effectively that he now reads braille library books; the Day Centre Manager, who had no experience with blind people, interviewed L. at hospital and offered to admit him to the centre. It was a real co-operative enterprise.

Statistical Summary

This report is not concerned with hospitals for the mentally ill, which have a total in-patient population of approximately 100,000. Condover ex-pupils are resident in hospitals which deal with severely subnormal and subnormal people, though the tendency now is to use the term mental handicap instead of subnormality. The 1973 edition of Health and Personal Social Service Statistics gives the total of in-patients in Hospitals for the Mentally Handicapped for the year 1971 as 55,893.

Dr G.B. Simon, Medical Director of the British Institute of Subnormality, tells me that he estimates that the number of visually handicapped people in hospitals for the mentally handicapped is of the order of 2,000.

My research survey concerns 41 Condover ex-pupils who form a very small proportion of the total of 2,000. I see no reason why the Condover people should not be treated as a representative sample of the total. The only way in which they are possibly different from the whole group is that they are younger, the eldest being aged 41.

Of the 41, 30 seem to be correctly placed in hospital because of the severity of their handicaps. 11 are less severely handicapped and do not need hospital treatment though they do need some kind of sheltered residence. They have been placed in hospital because no alternative residential accommodation is available. I must emphasise that this situation is not special to Condover ex-pupils who form part of the large number of people who are in hospital because of this lack of alternative residence.

Of the 11 considered for promotion, five have no parents and one has an unsuitable home. The five others have parents who decided that their sons and daughters needed residence elsewhere than at home. The reasons were various, but the most important were the adverse effect of the handicapped persons on the rest of the families, the lack of occupation and suitable companionship for them, and a desire by the parents to prepare for the time when through death or disability they could no longer care for their offspring.

Recommendations (a) for visually handicapped people in hospital

(1) Hospitals should have some sort of Unit for the visually handicapped, the staff of which would assess all visually handicapped residents and monitor their progress.

(2) The Unit should provide educational, occupational, and social programmes for all residents who could profit from them. There should be special emphasis on the development of independence in self-care and mobility for the blind.

(3) Co-operation between Unit staff and Ward staff is essential in the development of this independence.

(4) It may well be that Units will have to be developed by hospital staff who have no training or experience with visually handicapped people. Some sort of in-service training therefore seems necessary. Hospitals should make their training needs known to the Regional Associations for the Blind,pressing for the setting up of short courses. The Royal National Institute for the Blind may be able to give occasional help through its team of Educational Advisers.

(5) Liaison with the local Social Services Department should be set up on a practical basis through contacts between an experienced Social Worker for the Blind and the hospital Unit. The Social Worker could give advice to the Unit staff and also incorporate appropriate residents into activities for the handicapped outside the hospital.

(6) Although some segregation is necessary for the training and education of the visually handicapped, a conscious objective should be the integration, as far as possible, of individuals into the general social, training, and education programmes of the hospital.

Recommendations (b) of a more general nature

(1) Parallel with the drive towards placing as many hospital residents in hostels outside the hospitals, more hostel-type facilities within the hospital should be developed. These hostels would be a training experience for individuals before they try to live in the community; the hostels would also be permanent living conditions for some fairly able residents who could never cope with the problems outside hospital care.

(2) There is a great need for co-operation between voluntary organisations interested in different types of handicapped and their co-operation with statutory bodies, particularly hospitals and Social Services.

(3) Charitable organisations and voluntary bodies for the blind or visually handicapped, which have finance available, should co-operate with hospitals in setting up residential facilities for the visually handicapped within or outside the hospitals. Such facilities should, preferably, offer accommodation for non-visually handicapped people also.

(4) This is a personal plea to hospital staffs: can something be done to humanise the vocabulary of hospital life? Why talk of 'patients' living in 'wards' and of residents who are capable of some freedom of movement, being 'on parole'? Etc., etc.

Finally, I recommend all readers who are not members of hospital staffs, to read the third paragraph of the section headed "Hospitals" near the beginning of this chapter.

CHAPTER 4

EMPLOYMENT AND OCCUPATION

Review of Contents of Chapter

An introductory section is concerned with the occupation potential of all ex-pupils. Improvement since approximately 1950 in the facilities for providing employment, training and occupation centres are described.

Statistics are given of the handicaps of the 64 ex-pupils who are the subjects of this chapter with some discussion of facilities concerning employment. There is a short evaluation of the reasons for non-employment of a considerable number of ex-pupils who, at school leaving age, were thought to be possibilities for employment.

The group of 64 is divided into three sub-groups. For each sub-group personal statistics are followed by a fairly large number of case studies to emphasise the variety of personal factors and the complexity of the employment situation.

(1) 42 people in open employment This group is sub-divided into two sections: 20 with no intellectual handicaps and 22 with intellectual handicaps — 21 moderate, one severe. An interlude concerned with literacy separates these two sections and reinforces the finding that many of the first section are not now multi-handicapped.

(2) 13 people in sheltered employment Emphasis is laid on the change of occupation in the workshops away from traditional crafts.

(3) 9 housewives who are not employed This section is extended to give brief details of the 24 ex-Condover pupils who are married.

There follows an analysis of mobility skills and brief information about leisure time activities. The chapter finishes with a summary and some recommendations.

When Condover Hall School opened in 1948 the possibilities for work for the pupils when they left school were confined mainly to the small number of more able pupils. The placement of blind people in open employment was still in its pioneering stage and was concerned chiefly with people whose prospects of success were very high and who would produce good publicity value for the placement scheme. Blind people with additional handicaps could not realistically be considered for employment in open industry. It was unlikely, too, that Condover leavers would be admitted to sheltered Workshops for the Blind. These Workshops, at that time, were concerned principally with the traditional skilled crafts and trades of basketwork, brush-making, machine knitting, etc. The attainment of minimum standards of skill and speed were required from prospective workers before they could be accepted permanently as workers. All these minimum standards were quite low when compared with sighted workers in these trades but they were much too high for nearly all Condover leavers to qualify for admission to the workshops. Most Local Authorities provided Home Workers Schemes for blind people but they were based on the same traditional trades as those practised in the workshops with similar qualification levels for admission to the Schemes.

In the present context I am using the work "occupation" to imply an activity of a simple work nature with little or no financial reward, but with important personal and social benefits for severely handicapped people and their parents. These benefits include some relief of family responsibility through its handicapped member being occupied daily away from home. For the handicapped persons themselves there are the benefits of reduction of boredom, the development of social contacts with other people, and the possibility of maintaining and possibly improving the minor manual skills developed at school. For most Condover leavers until the early 60's the opportunities of this type of occupation were restricted to occasional attendance at handicraft classes and social clubs organised by the Home Teachers of the local Blind Welfare Services. The frequency of attendance was of the order of one day per fortnight only and the classes and clubs catered mainly for the needs of elderly blind people. These provisions were not particularly suitable for Condover ex-pupils, but where they were available — and this was not true for all our leavers — they were certainly of help to the young men and women concerned. At best, the Home Teachers combined the class activities with home visits which gave much appreciated support to the family and sometimes provided a supply of materials to the blind person with a sales service for finished articles.

Staff Estimates of Leavers' Work Potential

The school staff have always had, as one objective of their school programmes, the development of children's manual skills with a view to eventual work or occupation. Staff discussions of children's progress have included their future prospects, which, in the early years, we scored on the pupils' record cards according to a five-point scale for 'Estimated Economic Possibilities'. With the poor opportunities available for leavers during the first ten years of the school's existence the staff's estimating of the economic possibilities for most children was a somewhat theoretical undertaking. Nevertheless, it was a very useful exercise for us. (I still think of school leavers, when considering their possible work or occupation according to our original five-point scale with modifications to fit it, in a more realistic way, to the facilities which are now available for them.)

The original scale for Estimated Economic Possibilities worked something like this:-

(i) If given some simple work such as simple domestic work, portering, or odd job occupations, one could hope that a pupil classified as (i) would be able to live an independent economic life, receiving no augmentation of wages. This work is suitable for people with some useful vision but not for the totally blind. During its first few years the school admitted some fairly able blind children and some definitely partially sighted children and we were able to promote a few of these to schools for the blind or schools for the partially sighted. We assumed that they would profit from training and placement schemes for "normal" visually handicapped school leavers so we automatically classified them as (i) or (ii).

(ii) The pupils in this category included those whom we thought might be admitted to Workshops for the Blind or Home Workers Schemes in spite of the difficulties of the high admission standards. The abilities of some people in Category (ii) might be higher than those classified as (i) because the jobs in open industry often involved less skill than the sheltered workshops trades. The reason why skilled workers in workshops were classified as (ii) was that their wages are subsidised and they are economically less independent than workers in category (i). In addition to prospective workers in workshops we

hoped that a few leavers would find sheltered work of a different kind — simple employment under sympathetic guidance where a charitably-minded employer would accept a seriously handicapped person under special consideration.

(iii) Pupils classified in this category, though considered unable to work in open or sheltered conditions could, nevertheless, carry out simple handicraft or work activities reasonably well.

(iv) Pupils in Category (iv) were considered able to perform only very simple tasks but were a little more capable than the pupils in Category (v).

(v) Pupils in this category were unable to perform the simplest of tasks, even self-care, without some help. Many of them would need hospital care or nearly complete care at home.

Improvements in Provision of Work and Occupation

The above statements describe the position from 1948 until about 1958. Since then there have been considerable improvements in the welfare of handicapped people, particularly of the seriously handicapped. This means that blind multi-handicapped school leavers have rather better prospects for work and occupation now and many ex-pupils of Condover have already profited from the changes in the former facilities and attitudes and, particularly, from the development of new provisions. The chief improvements, which have a considerable element of inter-dependence, are:-

(1) Many more blind people of average and superior ability are now employed in open industry. Opportunities for employment include occasional placements in suitable higher professions, while a considerable number of blind people become physiotherapists, telephone operators, piano tuners, etc. These occupations are rarely suitable for multi-handicapped people. Many blind people, however, have found factory work such as simple machine operation, packing, and assembly, and some of these processes are certainly suitable for the more able Condover leavers.

(2) Two developments have been of great help in the work placement of young blind people of average ability and these have also been to the advantage of some more able Condover leavers:-

(a) In 1956, arising from recommendations of the Working Party Report on the Employment of Blind Persons which was published in 1951, the Royal National Institute for the Blind opened Hethersett, at Reigate in Surrey, a vocational assessment centre for blind school leavers and the centre's services have been extended to cater for some partially sighted young people. In 1964 a second vocational assessment centre, Queen Alexandra College, was established by the Birmingham Royal Institution for the Blind. These two centres, which work in co-operation with one another, provide both vocational assessment and a placement service as part of the national educational provisions for visually handicapped young people. The staffs of both Hethersett and Queen Alexandra College have always given sympathetic consideration to the admission of more able Condover leavers.

(b) In 1945 the R.N.I.B. began to develop an employment placement service for blind people which laid special emphasis on finding them employment in open industry. Comparable services were provided later by the Birmingham Royal Institution and one or two Local Authorities. The success of these pioneer efforts led to the founding by the then Ministry of Labour of a national placement service for the blind through Blind Persons Resettlement Officers, who include blind school leavers among their clients. The R.N.I.B. continues to provide this

service in the specialised fields of administrative and professional employment together with research into new forms of placement and employment. The R.N.I.B.'s placement officers are also connected with Hethersett and Queen Alexandra College and provide liaison between these two centres and B.P.R.O.'s throughout the country. Since 1965 the R.N.I.B.'s placement officers have provided a direct service to Condover and have extended their placement efforts to help leavers who are suitable for "occupation" rather than employment. In 1969 Condover Hall School staff began to take an active part in the placement of the school leavers. One of the teachers spent a few weeks each year visiting occupation centres and placement officers in the home areas of children who were nearing school leaving age. In 1972 this service was developed considerably with a teacher being appointed as Careers Officer. This man is still based at the school but he devotes approximately three-quarters of his time to exploring placement possibilities and in providing a follow-up service with families and Social Service Departments.

(3) There have been considerable changes within Sheltered Workshops for the Blind. Much of the skilled work of the traditional crafts is being replaced by industrial occupations such as furniture manufacture, plastic injection moulding, light engineering, packing and assembly. The whole topic of sheltered employment for disabled people generally is at present under discussion, prompted by a Consultative Document entitled "Sheltered Employment for Disabled People" which was published by the Department of Employment in 1973. This publication reveals that nowadays approximately one fifth of the work force of 3,000 employees in Workshops for Blind are sighted physically handicapped people. It is likely that this tendency to incorporate handicapped people of different types in the same workshops will develop further. This, together with the new types of work referred to above, could lead to the acceptance in Workshops for the Blind of more fairly able multi-handicapped blind people who, to date, have been excluded.

(4) In the past twelve years there have been some minor developments in the provision of "occupation" in day centres for blind people. The more significant improvements seem to me to have taken place in areas where joint facilities have been provided for blind people and physically handicapped people and in what I can best describe as "community centres for the handicapped".

(5) A very important development has arisen from the Mental Health Act of 1959, which laid upon Local Authorities the obligation to set up Adult Training Centres for the Mentally Handicapped. Since this development has given significant help to multi-handicapped blind people, including many former Condover pupils, I shall develop discussion of the topic in detail in Chapter 5.

(6) The Birmingham Royal Institution for the Blind established in 1950 the only specialised day occupation centre for multi-handicapped blind people — a most interesting pioneering undertaking, described in Chapter 5.

(7) In the early 1950's the Royal School for the Blind at Leatherhead extended its facilities to include care for younger multi-handicapped blind adults. The School not only provides residential accommodation but also a very effective occupation centre with a distinctly work-orientated atmosphere, especially for the men. (It should be noted that the description "School" is of historical interest only, the school having been closed many years ago. The Leatherhead committee has, for many years, offered residence to aged and infirm blind adults.)

(8) In 1969 the Committee of the former Yorkshire School for the Blind opened

the Wilberforce Home for Multi-handicapped Blind People, which provides residential care for the severely physically handicapped blind. The Home also has an occupation centre which is organised on occupational therapy lines.

Revised Scale of Occupation Estimates

In the light of the new developments I have used for my research purposes a modified form of the Occupation Estimate scale. The first four categories concern people who seem suitable for:- (i) open employment, (ii) sheltered employment, (iii) effective work in an occupation centre, and (iv) diversionary work in an occupation centre. Category (v) is reserved for people deemed incapable of profiting from any of these four opportunities.

Ex-pupils in employment will be discussed in the present chapter, those in occupation centres being dealt with in Chapter 5.

People in Employment

Group 1. Open Employment The number here is 42, of whom I have interviewed 41. Personal questionnaires were sent to 39 people and 38 completed forms have been returned. The one whom I failed to see was, at the time of my visit, away from home convalescing after an eye operation. This man is one of three brothers who were all pupils at Condover and I interviewed his brothers and his mother and I was able to gather reliable information about him from them. In addition, the man has recently telephoned me.

Group 2. Sheltered Employment The number here is 13, all of whom I have interviewed. Personal questionnaires were sent to everyone and ten completed forms have been returned.

Group 3. Housewives The number of people in this group is nine, all of whom I have visited. Two other housewives have been included in the Sheltered Employment section. Personal questionnaires were sent to everyone and seven completed forms have been returned.

Table 4.I gives statistics on each of the three groups, based on the subjects' handicaps at the present time. A summary of my scoring scheme is given on page 24. For easy reference a copy of the summary is printed on the bookmarker.

Table 4.I Handicaps of People at Work. Total Number : 64. Average age : 31.2, Age range : 21-41.

		Open N=42	Sheltered N=13	Housewives N=9	Total N=64
Sex	M	37	9	0	46
	F	5	4	9	18
Visual Handicap	PS	16	8	3	27
	PB	14	4	3	21
	B	12	1	3	16
Intellectual Handicap	NIL	20	4	3	27
	A	21	9	5	35
	B	1	0	1	2
	C	0	0	0	0
Physical Handicap	Nil	39	10	8	57
	a	3	1	0	4
	b	0	1	0	1
	c	0	1	1	2
Behaviour Handicap	Nil	38	12	9	59
	m	3	1	0	4
	M	1	0	0	1
Deafness	Nil	38	12	9	59
	d	1	0	0	1
	D/B	3	1	0	4
Epilepsy	-	4	0	0	4
Work-Occupation Estimate	i	21	3	4	28
	ii	18	9	3	30
	iii	3	1	2	6
Promoted	-	9	3	3	15

Comments

(1) Table 4.I gives a general picture which will be discussed in detail later with an anlysis of factors affecting placement in work and with consideration of actual personal situations.

(2) The large number of people in open employment compared with those in sheltered employment is explained (a) by the small number of sheltered workshops and their haphazard geographical distribution, which means that no workshop is available for many ex-pupils and (b) that the placement services for school leavers tend to favour employment in open industry.

(3) The housewives have been placed in the chapter on People at Work because it seemed the most appropriate. I consider that the work which they do is at least as skilled and important as most of the employment situations. When I had assembled the statistics concerning workers it became clear that the ratio of men to women in employment is greatly biassed in favour of the men (46 to nine). The placement of housewives among the workers redresses the balance somewhat, though I did not plan their inclusion for this purpose.

Factors Affecting Work Table 4.II compares the handicaps of the people at work with those for the total of 314 people who are the subject of the complete research. The number of 64 people at work has been reduced to 62 by subtracting two housewives who are definitely incapable of open or sheltered employment: one has a physical handicap (c) and the other has no employment potential.

Table 4.II Factors Affecting Work. N=62.

		Numbers		Percentage	
		Total	Workers	Total	Workers
Sex	M	190	46	61	74
	F	124	16	39	26
Visual Handicap	PS	75	27	24	42
	PB	102	20	32	34
	B	137	15	44	24
Intellectual Handicap	NIL	61	26	19	42
	A	129	34	41	55
	B	82	2	26	3
	C	42	0	13	0
Physical Handicap	Nil	220	56	70	90
	a	31	4	10	7
	b	36	1	11	1
	c	27	1	9	1
Behaviour Handicap	Nil	207	57	66	92
	m	68	4	22	7
	M	39	1	12	1
Deafness	Nil	270	57	86	92
	d	20	1	6	1
	D/B	24	4	8	7
Epilepsy	-	65	3	21	5
Promoted	-	27	15	9	24
Work-Occupation Estimate	i	43	28	14	45
	ii	73	30	26	48
	iii	81	4	23	7
	iv	67	0	21	0
	v	50	0	16	0

Comments based on comparison of the statistics for the workers group with the complete research population

Sex Of the seven housewives who have been included, six were employed before they married and the other was of very good employment potential. Even with the addition of these seven housewives the male-female ratio of 74% to 26% for the workers group is much higher than the ratio for the complete group, i.e. 61% to 39%.

There are no conclusions that I can draw about these ratios, except that there is nothing unexpected about them. I will simply make two observations:-

(1) In 1971, the national figures for employment showed that there were nearly 16 million men and nearly nine million women at work, a ratio of 64% to 36%. Many women were not at work because they were married. Only 11 ex-Condover girls have married.

(2) The type of work most frequently undertaken by ex-pupils is labouring, which is not suitable for women.

Visual Handicaps It is obvious that it will be easier for employment to be found for visually handicapped people who have some useful vision than for the blind. Comparison of the percentages in the lines for the visual handicaps for the Research Group and the Workers Group bears this out. The bias in favour of people with some sight is demonstrated more markedly when the total numbers of

individuals in each visual handicap category are compared with the respective numbers at work:- Partially Sighted, of a total of 75, 27 are employed, i.e. 36%; Partially Blind, of a total of 102, 20 are employed, i.e. 20%; Blind, of a total of 137, only 15 are employed, i.e. 11%.

Intellectual Handicaps The factor of comparatively high intelligence is obviously important in obtaining employment. Table 4.II shows the great preponderance in the group of workers of people with intellectual categories of Nil and A, i.e. 60 compared with only two in category B. It is interesting to consider the combination of visual and intellectual handicaps in individual people as shown in the tabulation below:-

Visual Handicaps	Intellectual Handicaps			Totals
	Nil	A	B	
PS	6	19	2	27
PB	10	10	0	20
B	11	4	0	15
Totals	27	33	2	62

This shows the importance of higher intelligence for the blind, working ex-Condover pupils and is an illustration of the generally held opinion that, to succeed in employment at any level, totally blind people need to have higher abilities than the norm for the job. Of the 15 blind people, only four have an intellectual handicap, whereas of the 27 partially sighted people 21 have an intellectual handicap.

Physical Handicaps and Behaviour Handicaps The small incidence of both these types of handicaps among the employed people is to be expected. The interesting fact is that some people thus additionally handicapped have actually found work. These cases will be referred to in later discussions of people at work.

Deafness The rather surprising fact that four deaf-blind people are working will also be discussed later.

Employment/Occupation Estimates Comparison of the figures for the total research group and the sub-group of those at work reveals that only 28 of the 43 people estimated to be in category (i) and 30 of the 73 people estimated to be in category (ii) are to be found in the "At Work" group. For the purpose of the present discussion I will not relate category (i) estimates strictly with open employment and category (ii) estimates with sheltered employment but consider them both as estimates of employability in a general sense. I will, however, discuss in some detail the large gap between estimates of employment potential and the actual work placements. There are two possible explanations of the apparent lack of employment for many people deemed suitable for work by the school staff:-

(a) The school estimates could probably have been over-optimistic, especially in the early days. (When I modified the original Occupation Scale in the light of recent developments perhaps I should have made more drastic individual re-assessments, but I wished to avoid the situation that, knowing the ex-pupil's present placement, I could have replaced the estimates with a statement of the present placements, thus giving an impression of almost completely successful forecasting.)

(b) The school estimates could have been reasonably accurate, with the ex-pupils not being able to realise their potential because of lack of appropriate placements.

The Missing People with Possible Work Potential Since this topic is of some importance I have assembled information concerning the "missing" 15 people of category (i) and the 43 of category (ii), i.e. those who, at school leaving, were thought suitable for employment, but are now not employed.

Of the 15 in category (i) four worked for some years in open industry but are now out of work and seem unlikely to seek work again; one has summer time employment in a sea-side cafe and does some craft work in the winter; six would like to work and have some potential but have no opportunities; one is unable to work because of ill health; three are in a residential placement and seem unlikely to find the work of which they may well be capable.

Of the 43 in category (ii), 18 would have been more realistically placed in category (iii); five have had illnesses involving behaviour disorders which make work placement impossible; two have had courses of rehabilitation aimed at work placement but they have failed; five, who have had some work experience, have no desire to work again; 13 could possibly manage sheltered work if it were available in their area, but the admission standard to workshops for the blind might prove too difficult for most of them.

Promoted People 27 people of the whole research group were promoted to schools for less handicapped children and were automatically placed in either category (i) or (ii). 15 are in the group at work. Of the other 12, nine are among the non-working people enumerated in the previous section; one is still at the school to which she was promoted; one physically handicapped young man, now aged 22, is still awaiting some form of training and work; the health of another physically handicapped man makes work impossible.

Group 1. People in Open Employment

Economic Earnings

In Tables 4.I and 4.II I have been discussiong "disembodied" handicaps, but now I begin to discuss individual people, their handicaps, their types of work and other relevant factors. Before I print Table 4.III, which will indicate the types of work undertaken by people in open employment, I give a case description of the only person in the group who has the severe intellectual handicap which I rate as (B). His case illustrates the question of the economic earnings of handicapped people, i.e. is the value of the work they perform commensurate with their wages?

Mr. B.I., now aged 36, who is definitely seriously intellectually handicapped but has quite good sight, has been employed as a labourer by the same small firm for nearly 20 years. He is paid well below a normal wage, the money which he receives being approximately 25% above the Social Security Benefit to which he would be entitled if he were incapable of employment. At the time of my visit, Mr. B.I. and his parents were delighted because the young man had, completely on his own initiative, applied for and received a small rise in wages. Does Mr. B.I. really earn the money he receives? Is there a charitable element on the part of the employer? Is the employer exploiting a handicapped person? B's parents are happy that their son has some occupation and he himself feels that he is a worker, is keen to go to work, punctual, etc. The parents have misgivings about the low level of his wages but do not wish to interfere in case such action should lead to their son's dismissal. (In planning my research I felt diffident about enquiring too deeply into the work situation of ex-Condover pupils in open employment but, in retrospect, I wish I had approached the matter in a more probing manner.) My personal opinion is that Mr. B.I., while he is restricted

in the amount and type of the work he can perform, is worth more than the wage he is at present receiving, though not the normal rate for the job.

The Disabled Persons (Employment) Acts of 1944 and 1958

At this point it seems relevant to refer briefly to these Acts, since they make provisions which are relevant to employable Condover ex-pupils. All employers of 20 or more people are required to have a quota of 3% disabled people in their work force. Quoting from the Official Notes for Guidance, "the object of this measure is to enable men and women who are handicapped by disablement to get work which is suitable for them and which makes best use of their skill". This seems to imply that such disabled people should be economically satisfactory employees achieving normal standards of output. It is very rewarding to seriously handicapped people to find employment in this way, but, unfortunately, there is disquieting evidence that some employers are able to include quite minimally handicapped people in their quota thus reducing the possibilities of employment for seriously handicapped people. On the other hand there are a few charitably-minded employers providing employment for some handicapped people who are unable to carry out a full work programme.

Relevance to Condover Workers

What I have written about Mr. B.I. and the Acts are relevant to the 41 people whose work placements are shown in Table 4.III below. I make the following comments:-

(i) I have seen ten of the people actually at work and in all cases received assurances from responsible staff that they were effective, economically viable employees.

(ii) I have no reason to doubt that 25 other people, all of whom I have interviewed but not seen at work, are receiving satisfactory wages and are economically viable propositions for their employers. Factors supporting my decisions included amount of wage, length of employment, the types of job and the attitudes of the former pupils themselves.

(iii) I think there is probably an element of charity about the employment of three people including Mr. B.I. and they would not find comparable employment and wages elsewhere.

(iv) In two other cases wages seem too low but this is probably due to the fact that the young men concerned began to work at the age of 19 alongside younger sighted employees and are paid at the rate for these younger people. It seems likely that these two ex-Condover pupils will reach the adult rate of pay, but later than normal.

(v) No comments can be made about the two people at present unemployed except that they are seeking employment through the usual channels.

Table 4.III Combined Visual-Intellectual Handicaps of People in Open Employment. N=41 i.e. 42 less Mr. B.I. mentioned previously

Vision	Intellectual Handicaps	
	Nil (N=20)	A (N=21)
PS N=15	Men: 1 tuner 1 labourer 1 unemployed (school porter) Women: None	Men: 6 labourers 1 light industry 2 assembly Women: 2 packing 1 domestic (hospital)
PB N=14	Men: 2 light industry (1 unemployed) 1 labourer 1 assembly 1 typist 1 tuner Women: 1 assembly 1 auxiliary teacher	Men: 3 labourers 3 light industry Women: None
B N=12	Men: 3 tuners 2 telephonists 2 typists 2 assembly Women: None	Men: 2 light industry 1 assembly Women: None

20 People with No Intellectual Handicap

Table 4.IV gives some personal statistics, which I can use as a basis for the case descriptions which follow. In the descriptions I shall not refer to age, home, etc., except where it seems appropriate to do so. The initials are used for identification purposes and are not people's real initials.

Table 4.IV Some Personal Statistics. People with No Intellectual Handicap. N=20

Visual		Work	Age	Home	Other Handicaps	"Type"
PS	Mr. H.C.	Tuner	37	L	None	P
PS	Mr. E.T.	Labourer	37	L	None	r
PS	Mr. E.Y.	Porter (unemployed)	39	M	None	R
PB	Mr. K.Q.	Light Industry	30	P	D/B	SrV
PB	Mr. N.C.	Light Industry(unemployed)	33	L	None	P
PB	Mr. N.L.	Labourer	25	P	None	rV
PB	Mr. E.R.	Assembly	21	P	d	rV
PB	Mr. K.D.	Typist	33	L	m	S
PB	Mr. D.S.	Tuner	40	M	None	R
PB	Miss E.D.	Assembly	35	P	None	P
PB	Miss E.F.	Teacher	37	I	D/B	S
B	Mr. D.C.	Tuner	35	L	None	r
B	Mr. T.I.	Tuner	28	M	None	P
B	Mr. C.R.	Tuner	34	M	None	P
B	Mr. J.C.	Telephonist	37	M	None	R
B	Mr. B.Y.	Telephonist	37	M	None	P
B	Mr. D.E.	Typist	27	P	None	P
B	Mr. M.B.	Typist	41	L	None	S
B	Mr. E.C.	Assembly	27	H	D/B	SV
B	Mr. S.D.	Assembly	22	P	None	rV

The column "Home" indicates the subjects' domiciles, the key being:-

H : Hostel.
I : Lives independently in own house or flat.
L : Lodgings (where a person still lives in the parents' home, but lives as independently as a non-handicapped son or daughter would, this is also scored as L).
M : Married, living in own home.
P : Living with parents under more protected conditions that those implied by L.

The column "Type" relates to comments below:-

P : Promoted.
R : Rehabilitated by end of school period.
r : Rehabilitated after a period of training and/or work after leaving school.
S : Special case.
V : Had vocational assessment at either Hethersett or Queen Alexandra College.

Comments

(1) If these people have only a visual handicap, they can hardly be correctly described as multi-handicapped. Indeed, the question can be asked — why were they at Condover? The 20 people can be divided into three groups: the promoted, the rehabilitated, and the special cases.

(2) The seven promoted (P) are pupils whose stay at Condover was, in effect, a period of remedial education which led to their transfer to schools for the blind and, in one case, to a school for seeing children. They joined the main stream of educational, vocational and placement facilities for visually handicapped people without other handicaps.

(3) The three rehabilitated by school leaving age (R) were considered suitable for training or placement and for whom success was expected. Five people who were partially rehabilitated by school leaving age (r) were recommended for training though success was by no means certain. Their rehabilitation was completed during training.

(4) These seven promoted people and the eight who can be considered to have been rehabilitated are no longer multi-handicapped. This leaves five people whom I wish to treat as special cases (S), three of them being deaf-blind.

Case Descriptions

I will now consider these 20 people, grouping them according to their visual handicaps.

(a) Three Partially Sighted The people in this group have no special problems and it would have been disappointing to have found that they had not worked. They are among the oldest ex-Condover pupils, their ages ranging from 37-39.

(b) Eight Partially Blind Four of the people in this group attended Hethersett, the first two after promotion from Condover and the other two direct from Condover.

Mr. N.L. and Mr. E.R. are among the youngest people in the group — aged 25 and 21, respectively. Neither were by any means certainties for success when they were transferred direct from Condover to Hethersett. It was a pleasant surprise to find that they were working and this is a tribute to the work of the staff of Hethersett and its placement officers.

Mr. N.L. has had several jobs, mostly of short duration. Reasons for leaving included his becoming redundant and, in his own words, "I just didn't like the work". Mr. N.L.'s ambitions are somewhat unrealistic and he talks of preferring "engineering", though he admits that he failed training in capstan lathe operating because "my arithmetic let me down". Above all, he says, he would like to work with handicapped children. During the course of my research Mr. N.L. has left one job in a small factory where he had worked for more than a year as a labourer in a paint-spraying shop. His wages were low, possibly because he could not manage the actual spraying. Recently he has taken up a better paid labouring job in an engineering firm working with fibre glass but he is a good example of my difficulties with borderline decisions when classifying individual's handicaps. N. is nearly partially sighted, nearly (A) for intellectual handicaps and nearly (m) for behaviour handicaps. With some misgivings I have classed him as having no additional handicaps now and as "rehabilitated".

Mr. E.R. has a hearing loss fairly well compensated for by the use of a hearing aid. His intelligence is only just within the normal range. It was after some deliberation that I finally decided to consider him as "rehabilitated".

Miss E.F. is a very exceptional case — and person. She acquired her visual and aural handicaps as after-effects of tubercular meningitis which she suffered one year after she had begun to attend a grammar school. She still has some vision which is very useful socially but she has to read braille. Although Miss F. is almost completely deaf she has managed to retain fairly easily intelligible speech. After recovery from illness she attended the deaf-blind department at Condover where she quickly learned the deaf-blind manual and braille. She made remarkably good educational progress, passing three 'O' level examinations within 18 months. Chorleywood Grammar School for Girls with Little or No Sight admitted her and within three years she had passed more 'O' levels and two 'A' level examinations. Then came the difficult problem of finding employment. The usual avenues for further education and professional training open to intellectually gifted blind people were closed to Miss E.F. because of her deafness. After a frustrating period when no suitable work could be found for her, she was employed at Pathways in no specific capacity. She soon showed her skill in dealing with deaf-blind children in and out of the classroom. She was given special permission by the Department of Education to take the examination for the College of Teachers of the Blind Diploma for Teachers of the Blind. Candidates for this Diploma must normally be already qualified as teachers, but there was no way in which Miss E.F. could study for the normal qualification. She succeeded in obtaining the College Diploma and is now permitted officially to teach blind children provided they are deaf. She is, indeed, a very successful teacher and she leads a remarkably independent life. She is buying her own house and supports her elderly widowed mother.

Mr. K.Q. is also deaf-blind. At Condover he had good vision of the partially blind category but this has now deteriorated and he is nearly blind. He has always been severely deaf. He went direct from Condover to Hethersett where he was considered employable though, naturally, in need of special care in placement. He has been employed for about ten years in a large factory producing radionic goods. His work is of a simple repetitive type and involves the use of a guillotine. His employers state that Mr. K.Q. really earns the money he is paid. He is well liked by the workers and in particular by the people in authority on the shop floor who ensure that he gets the little personal services he needs such as help in moving about the crowded shop and in reaching the transport provided for the workers. Provided he catches the correct 'but he can get off at the end of his own road and easily find his way home, where he lives with his parents.

Mr. K.D. is the third of my "special cases" in the partially blind group. He is now aged 33, but only began to work a year ago. He is employed in a Government department and lives in a flat in London, after having lived for most of the time since he left school with his widowed father in a fairly remote West Country village. I am amazed that he had found employment, but it seems to be due mainly to his own persistence and the urging of his father. His case is most unusual. At school K.D. was very irrational, with obsessional interests and conversation. In the classroom he achieved a fairly good standard, somewhat above the Condover average, but not suitable for promotion. He was completely competent in self-care. The oddities of his behaviour led the staff — and me — to give him an occupation estimate of (i) (0) meaning that if he were not so odd in behaviour he could become an independent worker. Somehow we could not imagine K becoming a factory worker, and successful training in typing or telephony seemed most unlikely.

Mr. K.D. took a special typing course at the Royal Normal College. The course was aimed at making him useful at home rather than in employment, but it proved to be unsuccessful mainly, I suspect, because of temperamental clashes between K and the other students and the staff. In his middle and late twenties, Mr. K.D. passed two 'O' levels and when I finally traced his whereabouts his father told me that K was taking a 'crash' course for 'A' levels with a view to admission to a theological college with the aim of becoming ordained. Then he hoped to take a post as Chaplain in a school for the blind, teaching braille and religious knowledge. He failed to get the necessary 'A' level grades. Meanwhile he had also been taking an eight month typing course and this has led to his present employment which has lasted for a year. His chief hobby is the Christian religion and he is learning Hebrew so that he can read the Bible in that language. Mr. K.D.'s progress is a real, if unusual, success story.

(c) Nine Blind People All the nine men in this group are totally blind. Seven are employed in posts which are considered to be particularly suitable for blind people of average ability with some literacy skills. Messrs C.R., B.V., and D.E. were promoted to blind schools early enough for them to have rejoined the normal stream of education and to need no special comment here, but I will give some details of the other six people.

Two tuners present similar features of interest though I have not designated them as "special cases". Both of them were rejected as infants and had a very poor start to life, but made unexpected and remarkable progress in late childhood and adolescence and have developed into independent blind workers.

Mr. T.I. spent the first five years of his life in a residential nursery for seeing children where he was given almost no stimulation. At the age of five he was described as a bed-ridden idiot but then began a really remarkable series of improvements. T was transferred to the Ellen Terry Home for Severely Subnormal Children where he made considerable progress before he was transferred to Condover at the age of 10. Here rapid progress was continued and at the age of 13 he was promoted to Lickey Grange School for the Blind. Three years later he began a course of piano tuning at the Royal Normal College. After successful completion of this course he took up work in a piano factory where he joined Mr. D.C.

Mr. D.C. also had an unfortunate beginning to life. As a baby he was neglected and had to be taken into Care where he remained until he was adult. He had no settled life as an infant but, after a slow start at Leamington Sunshine Home and later at Condover where he arrived at the age of nine, a series of improvements began. These were not as sensationally rapid as those of Mr. T.I. but were, nevertheless, quite remarkable. D as an infant had not been as grossly

retarded as Mr. T.I. but he was on the borderline of severe subnormality. I measured his intelligence twice:- when he was 11 years old I obtained an I.Q. of 66 and two years later I registered an I.Q. score of 82. Now his intelligence is well within the normal range. Throughout these years and later, D made considerable progress in academic education, well above the Condover average. Although, in self-care, he slowly improved and eventually became nearly independent, he remained very retarded in practical skills, both in work and in the development of orientation and mobility. On the other hand he made remarkable progress in piano playing which surely implies some manual dexterity and orientation. At the age of 13 he had begun to succeed in the examinations of the Associated Board of the Schools of Music and by the age of 16 had reached a standard equivalent to 'O' level in Music. He was recommended for admission to the piano-tuning course at the Royal Normal College and was accepted. We had doubts about his success because, although he had considerable musical gifts and a remarkably accurate ear, his manual ability was still very restricted. However, Mr. D.C. qualified as a piano-tuner, but not as a repairer, and was found employment at a piano factory where a senior official of the firm has recently described him to me as being an effective, reliable worker. When, about seven years later, Mr. T.I. took up work at the same factory, Mr. D.C. was able to initiate him into employment there.

I would like to make a few points about the progress of Messrs D.C. and T.I. For the school staff it was not so much a matter of planned remedial education, but rather the provision of an atmosphere in which the improvement could take place. We were spectators of a developmental phenomenon which we were able to assist by providing the appropriate encouragement towards personality growth. Two general comments seem valid:- (a) the development of the pre-school advisory services which are already in existence should minimise the ill-effects of neglect and rejection of blind babies, and (b) the educational services for blind children — and no doubt for other types of handicapped children — should pay attention to the possibility of unexpected improvements in adolescence.

I now turn to the case of Mr. O.B., one of my "special cases". At school he was obviously of at least average intelligence but his progress was grossly hindered by his behaviour problems which included startling irrational verbal outbursts with episodes of aggression against objects rather than persons. His one educational success was in braille, in which he was very competent. He only came to Condover for the last year of his school life which coincided with the first year of the school's existence. Previously he had spent five years at Court Grange School which was then absorbed into Condover. He left school at age 16 but the staff felt that there would be no likelihood of him finding work and his behaviour prevented his admission to the Royal Normal College. I had no contacts with Mr. O.B. for many years and then heard that he was employed as a typist. I was rather surprised and I assumed that he had been found some sheltered, charitably-based employment. In my research survey, I was very pleasantly surprised to find that he is an independent, economically effective worker, living a full life and that his behaviour problems are a thing of the distant past. How was this change achieved? Mr. O.B. received no psychiatric treatment, but the improvement was brought about by patient education with increasing co-operation from the young man himself, all aimed at the tangible goal of employment. Once the preliminary stages had been passed there was a marked acceleration in progress. He was taught braille shorthand by a blind Home Teacher; he struggled to learn typing with his mother (her own description!) and then he took a typing course at the local Technical College and became a fully qualified typist. Only three years after leaving school he was offered a job with a local firm where — and this is no doubt a relevant factor — several members of his mother's family had been employed. His work here was of such high standard that he was transferred

from the typing pool to more interesting and responsible work in the Buyer's Office where he still works. Mr. O.B. lives with his parents who are now elderly, but he is not in any way dependent upon them. He could afford to live in lodgings or even employ some domestic help and live in his own house.

My first comment on Mr. O.B.'s unusual case is a double question:- what would have happened if he had not been educated at a school very distant from his home? Would he have suffered his behaviour difficulties if he had lived — as he could nowadays — in a reasonably nearby school from which he could have spent all weekends at home? My second comment is:- a fortunate combination of circumstances led to this man's rehabilitation at a time in his life at which it would have been possible to have been resigned to the probability that no treatment would succeed. Mr. O.B.'s training seems very much like the treatment a psychiatrist might have recommended. It seems possible that other intelligent, emotionally disturbed blind adults might respond to the challenge of a special educational or training programme aimed at their potential employment if their behaviour difficulties were solved rather than urging them to resign themselves to a humdrum though apparently more realistic solution of their difficulties. I have in mind another ex-Condover pupil who is still at home after a long period in a day occupation centre of a therapeutic nature where he carried out repetitive industrial tasks which led to a trial in a sheltered workshop. The trial failed mainly because of his unco-operative, "superior", behaviour and his lack of ability and interest in repetitive manual work yet for some years he has attended advanced courses in Politics and Sociology organised by the Workers' Educational Association and has achieved some success.

The fourth person in this section is Mr. J.C. At the age of 12 J. contracted tubercular meningitis which left him blind and severely physically handicapped. He spent just over two years at Condover from the age of 14 during which his physical handicap nearly disappeared — I remember with pleasure the ceremony at which his walking sticks were thrown on the bonfire. He made good progress in braille and general adjustment to blindness. At age 16 he went for training for a sheltered workshop craft but ended by training as a telephonist and he has been employed as such for 17 years. He is married and has one child. He is a very effective owner of a Guide Dog. I mention Mr. J.C.'s case to draw attention to children who become blind during school age. He was of normal intelligence. Should he have gone to Condover or to a school for normal blind children? Although, in many cases, I feel that re-education should take place in a normal school I think that in some cases especially where there are additional handicaps, there is a need for a relaxed period with no undue pressures. A placement at Condover where part of the recuperative process is a realisation by a child that he is better than some of the other children could be very beneficial.

Finally in the blind group of the Nil Intellectual Handicap section I wish to comment on the two assembly workers. Mr. E.C. is deaf and blind and is now aged 27. His is a real success story and although from the age of five he spent 12 years at Condover, this success would have not been achieved without considerable co-operation from other organisations and people. Mr. E.C. is, of course, a code description following the pattern I have followed in this research report, but many visitors to Condover remember the vivid impressions E. made on them. I have decided to include case histories of E.C. and of the other three working, deaf-blind ex-Condover pupils in the appropriate places in this chapter on those at work, rather than in Chapter 8 which has a special section on the deaf-blind. It is very easy for people to be misled by a few individual success stories of deaf-blind people and to think that they are typical of such handicapped people generally and not to realise that the great majority of to-day's deaf-blind children have other severe handicaps in addition to their defects of vision and hearing. E. was illegitimate and his mother was unable to care for him

though she has kept in touch with him from time to time and continues to do so nowadays. In his infancy and childhood, E's grandmother helped him a great deal, but it was necessary for him to be admitted very early to the Ellen Terry Home for Severely Subnormal Blind Children. Here he received care and encouragement, so much so that, by the age of four, he demonstrated that he was certainly not severely subnormal. In 1952 just before his fifth birthday he was admitted, as one of its first children, to Condover's experimental Unit for deaf-blind children, which was later extended and became known as Pathways.

E. arrived at Condover having already made some progress in most facets of self-care. He had no means of communication but was friendly and co-operative. Fortunately he had some well developed personal traits which were very helpful, among them an intense but rational curiosity, a pleasant and amenable personality, and a desire to be active. The Head of the Unit not only planned E's education in his first years at Condover but carried out most of it herself. By the age of about nine he was beginning to take an interest in simple ideas and the Head sought the help of as many people as possible to broaden E's interests and there was a ready response. He took part in most of the Department's activities and later in the school activities too — excursions, camping, scouts, swimming, canoeing, etc.

There was, however, a difficulty about holidays. He could not often visit grandmother and his mother was living a kind of nomadic existence travelling round with her husband who was not E's father. Since the regulation of those days stated that the Local Authority in which E's mother was residing was responsible for his holidays, there were frequent difficulties about them. Sometimes he went to a Children's Home, sometimes he stayed with a member of Condover staff, rarely with the same people. Granted that a permanent, understanding home with his own parents would have been better, this changing pattern of holidays had its good points. Once he could use the deaf-blind manual he went off on his holidays with a photographic copy of the manual and some notes about his skill in its use. There were many possibilities for new vocabulary and new friendships. To E, Condover was, in a way, his home as it was for many staff who went away for holidays to different places — an idea which was developed with E. as his understanding grew. When E. was 14 years old, his mother's home was in a West Midlands town and that authority's Education Department became responsible for his holiday placement. This department consulted their Children's Department and the Children's Officer almost immediately asked me why E. was not in care. My rather lame reply was that the authority where E. was born had refused to take this action and I had supposed this decision was final. The Children's Officer took him in care at once and arranged for him to spend all holidays in the same Children's Home. He and his staff took a personal interest in E. and the Department continued to support him personally and financially when at the age of 17, he was transferred to Queen Alexandra College for vocational assessment.

He arrived at the College with a fairly effective knowledge of braille for simple reading and writing but with no desire to read books; very fluent use of the deaf-blind manual with much experience in teaching it to strangers with extraordinary patience in "listening" to the halting conversation which ensued; complete independence in self-care which included some simple cooking; independent mobility in known and essential areas of activity and the ability to learn his way around new places, excluding street travel; a moderate ability in handwork; and the good nature which has always been, perhaps, his greatest asset. The College staff continued his social education, gave him a very useful experience in meeting strangers and decided that he was employable. Fortunately he was, and still is, based on the same West Midlands town where the Blind Persons Resettlement Officer for that area of Staffordshire was a visually handicapped man of great drive and

persuasive powers, with a special sympathy for multi-handicapped blind people. He persuaded a manufacturing firm in the town to give E. a trial and he helped him through this period. After some initial doubts, the management, personnel officer, and the foreman and workers all accepted him warmly. E. taught many people the deaf-blind manual and communication problems were soon solved. The visit I paid to Mr. E.C. at work was a stimulating and quite emotional experience. He works at a fairly intricate assembly job and really earns his money but the most striking feature for me is the way E. is accepted by the workers who give him so humanely and naturally the companionship and occasional minor help which he needs.

E's living quarters proved a difficult problem and for most of his time there as a worker, which now amounts to eight years, he has lived in an Old People's Home. At first this seemed to me a regrettable placement which had to be accepted as the only possible residence. However, I have visited E. at the Home several times in the last few years and there are several commendable features about the situation. He has a comfortable bed-sitting room. He receives companionship and help from the staff who help him to organise and systematise his social life maintaining a diary for him which, incidentally, gets surprisingly full. He has had fruitful friendships with two or three active elderly residents with mutual benefits. Mr. E.C. pays for board residence and there is for him some approximation to the life of a lodger in his present situation. He uses taxis for going to work, for attendance at social functions, and for visits. He pays for some of these himself and receives help with the payment for others. His recreational activities include swimming, judo, and clubs for the deaf and the deaf-blind. He is unmarried although he has had several "girlfriends" whose intentions were, I suspect, more platonic than romantic.

Mr. S.C. the second assembly worker is now aged 22. At school his chief handicap was concerned with behaviour. He had what I can best describe as a fundamental insecurity with great lack of self-confidence. His family background did not seem to contribute to this since he was not rejected in any way. Until he reached the age of about 14 any little frustration lead to quite major emtional outbursts, reminiscent of a much younger child. The improvement began to take place slowly, probably arising from staff efforts to encourage his mobility in a way in which he could think was mildly adventurous. A course of tranquillisers also helped but were abandoned as further improvement took place. S. stayed at school till age 18 to extend the period of growth of his self-confidence and then was transferred to Hethersett, though we felt by no means certain that he would succeed. However, the Hethersett staff dealt with him with great understanding and eventually he was considered to be employable. Then began a period which could have been unsettling when no employment could be found. After a year or so he began to attend a Day Centre for the Handicapped where he was the only blind person. Here he received just what he needed — personal support and encouragement plus some work experience. This was an important contributory factor to his eventual placement in open employment where he has now worked for a year.

Important Interlude

Before reviewing the cases of the workers with a moderate intellectual handicap, I wish to make some important comments on the people I have already discussed. One of my reasons for discussing in such detail the 20 ex-pupils with no intellectual handicap is that there has been a gradual alteration in the handicaps of children admitted to Condover, an alteration which, over the years, has amounted to a very considerable change. Less severely handicapped children, who formerly would have been transferred to Condover, tend to be admitted, and retained, in schools for the visually handicapped. Only a few of the most

seriously handicapped are now passed on to Condover, and this applies to children suffering from physical or behaviour or intellectual handicaps or combinations of these. The vacancies thus created at Condover are taken by other very seriously handicapped children who would otherwise be either at home, in hospital, or in a very special school. To some extent this is the repercussion on Condover of the general policy, put into action in 1971, of incorporating "severely subnormal" children into the nation's educational system.

In Table 4.IV I listed each person's age and I summarise this information thus:- of the 11 "white collar" workers who had some form of professional training, nine are aged at least 33 and had left Condover by 1958. The two other, younger, people were promoted, one in 1959 and the other in 1960. Of the nine people doing less skilled work, four are at least 33 years old. In all, 15 of these 20 workers with no intellectual handicap left Condover by 1960, and the other five, who left after 1960, are in the group of less skilled workers. It seems, therefore, reasonable to consider the year of 1960 as a dividing line between the earlier time when there were more obviously employable pupils at Condover and the later period when it was less likely that even the most capable pupils would succeed in finding work. Certainly, since 1960 no former pupil has succeeded in training in piano-tuning, typing, or telephony. This change has meant that few blind ex-pupils now find employment.

However, this approximate date of 1960 also saw the beginnings of the beneficial effect on Condover of the vocational assessment programmes for "normal" blind school leavers. This important development is featured at the beginning of the section which follows this "interlude".

It seems relevant here to quote some statistics concerning the literacy of the two groups of workers in open industry, comparing the 20 people whom we have already discussed and who have no intellectual handicap with the 21 people with a moderate intellectual handicap who will shortly be considered. I have also added to the latter group the special case of Mr. B.I. (referred to on page 77) who has a severe intellectual handicap, thus making 22 in all.

In table 4.V I have placed all people in one of the reading media, braille or print. For people who are illiterate this placement indicates the medium appropriate to their vision. All had the opportunity to learn to read and write at school. The explanation of the scores in the columns for use of reading medium are:-

Much: people who read library books at the rate of at least six books per year and write a considerable amount. Some blind people who have learned to type write most of their letters by this method, though all can write braille.

Some: people who do a little reading and/or writing occasionally. The two most competent are a man who keeps in touch with sporting news and fills in his own betting slips and a woman who reads stories in a weekly magazine and writes letters home. For the others, use of reading and writing is much less frequent.

None: simply means no reading or writing at all.

Table 4.V Literacy of Workers in Open Employment. N=42.

	Appropriate Medium		Use of Medium		
	Braille	Print	Much	Some	None
No Intellectual Handicap N=20	16	-	13	1	2
	-	4	-	4	0
Intellectual Handicap A N=22	5	-	-	3	2
	-	17	-	5	12

At times I find myself using the term "proper Condovers" when describing pupils and former pupils. By this term I mean to indicate those people with one or more handicaps additional to their visual defects which are severe enough to make it unlikely that they would succeed in a normal educational programme and for whom special problems and challenges are presented when work and occupation are being considered. This excludes the promoted or the very easily rehabilitated on the one hand and the grossly multi-handicapped requiring almost total care on the other hand.

Table 4.V shows a striking contrast between the two intelligence groups. The people with no intellectual handicaps are mainly literate braille users, but I have already made the point that nowadays at least half of this group would be educated elsewhere than at Condover. I consider, however, that the deaf-blind were "proper Condovers" as were also the two other special cases Messrs K.D. and M.B. and the three youngest people, Messrs N.L., E.R., and S.D., whose success in vocational assessment was by no means certain.

The people with a moderate intellectual handicap are mainly illiterate or semi-literate people with some useful vision. The illiteracy is not surprising since their combined visual and intellectual handicap was the main cause of their failure to learn to read and write. Illiteracy is normally a handicap to successful work placement, and, although there is no reason for undue satisfaction, it has been gratifying to find that so many of these people are at work, since I consider that they are all "proper Condovers". It may be that, following the change in Condover admissions to which I have referred, some boys and girls of intellectual handicap (A) will not be educated at Condover in the future. In fact some are already at school elsewhere. Such children are not likely to become literate but it will be unfortunate if, because of this, they develop a feeling of failure which hinders successful work placement.

I end this interlude with a topic which I find disturbing: the lack of employment of blind ex-pupils. I admit that there are greater difficulties in the placing of the blind compared with the partially blind and the partially sighted. Nevertheless, if a few blind ex-pupils have been found employment why should not a few more people of approximately the same abilities also be found work? I do not wish this point to be overlooked as I now proceed to the examination of the work placements of ex-pupils with an intellectual handicap (A), the great majority of whom have some useful sight.

21 People in Open Employment who have an Intellectual Handicap (A)

There is an important difference between the people to be dealt with in this section and those described previously who have no intellectual handicap. With the non-intellectually handicapped I was thinking of rehabilitation which made them no longer multi-handicapped but simply visually handicapped. Whatever happens to the people in the present section they remain doubly handicapped — visually and intellectually. They could be described as mildly multi-handicapped.

Table 4.VI People with Intellectual Handicap (A). N=21. Some Personal Statistics.

	Work	Age	Home	Visual	Other Handicaps	"Type"
Mr. Q.B.	Labourer	24	L	PS	M	V*
Mr. F.D.	Light Industry	26	I	PS		V
Mr. E.C.	Assembly	24	P	PS		V
Mr. C.F.	Labourer	38	L	PS	a	r
Mr. B.I.	Labourer	31	L	PS		P
Mr. O.I.	Labourer	26	L	PS		V
Mr. G.M.	Labourer	38	M	PS		R
Mr. H.N.	Labourer	23	L	PS		S
Mr. S.T.	Assembly	22	P	PS	m	V
Miss T.B.	Packing	30	P	PS		r
Miss Q.M.	Packing	23	P	PS		V
Miss B.Q.	Domestic	37	L	PS		R
Mr. R.D.	Light Industry	22	L	PB		V
Mr. H.C.	Labourer	28	M	PB		V
Mr. S.M.	Labourer	35	M	PB	m E	r
Mr. B.M.	Light Industry	30	L	PB	m E	V
Mr. D.M.	Labourer	25	P	PB		V
Mr. S.N.	Light Industry	29	L	PB		V
Mr. O.D.	Assembly	30	L	B		r
Mr. L.E.	Light Industry	28	P	B	a	S
Mr. O.Q.	Light Industry	28	P	B		V

Notes

The Column "Type" N.B. In 1960 when vocational assessment began to be available for Condover ex-pupils, school leavers were aged 16 and they had attained the age of 30 in 1974. In the table there are, therefore, two age types:- those aged 30+ who had no chance of vocational assessment with associated training and placement services, and those aged 30 or less who might have had this opportunity.

P : promoted (to a school for the E.S.N.).
R : rehabilitated (suitable at school leaving age for direct placement into employment).
r : rehabilitated (no vocational assessment available but eventually found work).
V : had successful vocational assessment at either Hethersett or Queen Alexandra College, except where an asterisk indicates failure at the course.
S : special cases (deemed unsuitable for vocational assessment, but have found successful employment).

The Column "Home" indicates people's present domicile:-

I : lives independently in own house or flat.
L : lodgings (where a person still lives in the parents' home, but lives as independently as a non-handicapped son or daughter would, this is also scored as L).
M : married, living in own home.
P : living with parents, but under more protected conditions than implied by L.

Case Descriptions

I will now give case descriptions of each of the people in this section. I aim to give some idea of the variety of employment and high-light some facts

that could be important for work placements in the future for visually handicapped people, with or without additional handicaps. I will deal with the cases in three groups.

(a) The Three Blind People

Mr. O.D. had no occupation until the age of 24, when he began training as a basket maker in a sheltered workshop. I saw him there when he was coming to the end of a successful training. Because of difficulties in the supply of raw materials O. became redundant. However, he was quickly placed in a light industrial firm where he has settled down well.

Mr. L.E. is a dwarf with the usual physical characteristics of such people. At school he was one of the best pupils in handwork that we ever had — including the most sighted. In formal intelligence testing his results were low, but he was full of common sense. He was unable to learn to read and write braille. He has developed amazingly and in many ways he behaves as a normally intelligent adult. He has worked for ten years in a firm which produces soft toys and a large variety of small plastic toys and utensils. L. is able to use the firm's transport for travelling to and from work. He has his own low-placed coat peg on which to keep his short white cane, which, to him, is a long cane, and using this he is independently mobile about the factory, which has several departments and employs about 150 people. I quote from the notes I made at the time my wife and I visited Mr. L.E. at work: "Finally we went to the firm where he works and L. introduced us to one of the managers and several of his work-mates. Obviously he's a most effective worker and a well-liked colleague who is respected for the quality of his work. He showed us the two machines he works — one a compressed air drill, the other for printing small designs or pictures. He's quite independent with his machines and knows how they work..... Here we were being instructed and entertained by an interesting and enthusiastic man who just happens to be totally blind and a dwarf". Mr. L.E. lives with his widowed mother.

Mr. O.Q. was not placed in a job for at least a year after his assessment. Finally, his grandfather arranged an interview which led to a period of trial training in a large engineering firm. The Personnel Manager, and the shop foreman, took a keen interest in O's training and the firm's proprietor was sympathetic and encouraging. Mr. O.Q. has now worked for eight years. He works at a honing machine which prepares moulds for rivets. He manages the machine independently and needs no help with the changing of the moulds, etc., and tests the diameters with a series of gauges. Both the Personnel Manager and the foreman say that Mr. O.Q. is "worth every penny he earns". Fortunately Mr. O.Q.'s father's work is such that he can take his son to and from work en route from his own job. The distance to work is approximately five miles with no convenient bus route. I am assured that if difficulties in transport should arise, they could be easily solved. He is unmarried and lives with his parents. Part of his daily routine is that at home he gets up first, makes a pot of tea and takes cups of this to his parents in bed.

(b) Six Older People who had no Vocational Assessment.

The first five are partially sighted and the sixth is partially blind.

When Mr. C.F. left school he was found some occupation in doing odd jobs in the grounds of the Corporation's Homes. What began as a compassionate placement, has developed into a worth-while economic job. He is employed by his own Social Services Department and is a member of the appropriate Trade Union. This seems to be a development of an imaginative first placement of a handicapped person.

Mr. C.F. has a moderate physical handicap, in my classification ranked as (a). Since Condover, and many schools for the handicapped, have extensive buildings and grounds, perhaps there is a case for some vocational odd-job training while pupils are at school?

Mr. B.I. had slight physical and hearing difficulties at school, but these appear to have almost completely disappeared. For a long time he worked as a van delivery driver's mate, which seems a possibility for other ex-Condover pupils with useful vision, particularly in country areas. For the last two and a half years he has worked as a labourer in a tile-making process. His main job is shovelling sand into the sand-burning ovens but he works occasionally with the machines. By preference Mr. B.I. works all night shifts. He finds the work then less frantic with fewer people in the works. He also qualifies for a considerable amount of overtime which greatly augments his wages.

Mr. G.M. was an extroverted boy who simply did not seem to realise his handicaps. He came as a child from Malta and his fluent English was, and is, rather obscured by a marked accent. He is independent in thought and personal life. For a good many years he worked in the Parks Department of a Lancashire town. Later he took up factory work and now works as a labourer in a foundry where the pay is better. I was, at first, surprised to learn that he is now a shop steward, but later realised that this is, in a way, true to character. Although he never learned to read and write he was, as a boy, good in the understanding of money, forceful in character, honest, and had, in a strange way, some of the qualities of a leader. He is married, has two children and is buying his own house.

Miss T.B. has a surprisingly good work record. As a child she had a speech disability and an orthopaedic condition which showed itself in an uncertain walk. Her handwork was reasonably good but she was slow. These were contra-indications for employment and I was pleasantly surprised to hear that, soon after leaving school, she had found employment. When I visited her for the research survey she had been working for 11 years packing 'cheeselets'. Unfortunately the firm was about to move away from London and T. could not go away from home. For a time she attended a Day Occupation Centre but fortunately was found work again — sorting 'reject' packets of biscuits. Miss T.B.'s case illustrates good placement and welfare services. If she has worked successfully, surely other mildly multi-handicapped girls could do so. An unsolicited remark from T. was:- "I'd like to get married if Mr. Right comes along but if we have a baby, will the baby be like me?"

Miss B.Q. was one of the most competent of the pupils admitted to Condover when the school opened. By the age of 12 she was completely competent in self-care but she had emotional problems, being unstable and also very tense. These problems had lessened by the time she left school but they had not completely cleared up. Nowadays all seems well. She has been in her present job as hospital domestic cleaner for ten years. This is a very successful placement and might be suitable for other visually handicapped women though this type of work, with its need for cleanliness, is more suited for the partially sighted rather than the partially blind.

The work now performed by Mr. S.M. appears to be an example of an 'enclave' which in this context is used to describe a group of workers who include among them one or more handicapped people. Mr. S.M. had frequent epileptic fits at school and still has occasional attacks but these are now of a minor nature. When S. left school there was a possibility that he might be employed at the farm where his father was employed. I had almost decided to count Mr. S.M. as untraced, when fortunately I came across him in a different part of the country. I have not

been able to piece together completely his history but the essential details appear to be as follows:- at age 23 he went for rehabilitation at one of the R.N.I.B.'s establishments for adults. Here he met the visually handicapped young lady who eventually became his wife. For a time Mr. S.M. worked in a workshop for the blind in the Midlands but later moved south with his wife and two children to be near his wife's mother and father. Here he eventually found employment with the local Council. He is employed as one of the team of five men who deal with refuse collection and, in addition, clean the town once per fortnight. Officially Mr. S.M. is described as a 'lengthman'. Mr. and Mrs. S.M. live in a rented council flat and now have a third child. The two older daughters are aged eight and nine. Mrs. S.M.'s parents are of considerable help to the married couple who need it because of their handicaps.

(c) Seven of the 11 People who had Vocational Assessment (plus Mr. H.N.)

The first four and Mr. H.N. are partially sighted, the other three being partially blind.

Mr. Q.B. was discharged from his period of vocational assessment because of drunkenness. There were subsequent difficulties about placement, partly owing to his unco-operative temperament. He refused to consider attending an Adult Training Centre for the Mentally Handicapped even as a temporary measure. One day, quite unexpectedly, he found himself a job as a lift attendant and he augmented his low earnings by occasional overtime work as a cleaner. Recently he has changed jobs, again on his own initiative, and works as a porter in a large multiple shop, where conditions and pay are better. Mr. Q.B. lives at home with his widowed mother. Q's leisure time is centred almost completely around pubs and there is a definite danger that he may become alcoholic.

Mr. F.D. was transferred to Condover from a school for the blind, mainly because of his lack of progress in academic subjects. He seemed to over-compensate for this "failure" with a show of over-confidence which was uncertainly based. He has had many jobs, changing them because they didn't suit him. He tended to think he was worthy of more skilled types of work. It is possible that he has justified his belief in himself, since his latest placement involved a period of training and he is now working as a machine polisher at a machine tool factory.

Mr. E.C. came to Condover at age 13, after some years in a school for E.S.N. children. He was an extremely apprehensive boy with a marked speech defect. His confidence began to grow and he became quite competent manually and helpful generally. He has now been working for six years in his first job where he carries out light industrial processes involving the use of power presses. What a development for a worried, unconfident boy of 13!

Mr. O.I. found employment in a button-making factory where he was a labourer in some electrolytic process. O. is a very self-confident young man, very much a man of the world, and says that he told the boss "he could keep his job" when he was what he considered "being put upon". Mr. O.I. then attended a course on Gardening in a Government Re-training Scheme not normally concerned with visually handicapped people. True to form, he took on spare time gardening jobs to augment his income. He is partially sighted and is prepared to undertake most tasks so that many people are probably unaware of his handicap. He is now employed by a jobbing gardener and works in gardens and greenhouses.

Mr. H.C. thinks that his vision is worse than it was at school when I considered him to be partially sighted. Therefore I have now classed him as partially blind. He has worked for eight years in a large engineering factory.

He is a labourer in the drying room of a zinc treatment process where the conditions are hot and the work fatiguing but well paid. On one occasion Mr. H.C. says that a "senior management person" saw him peering closely at a bleed hole which he had to clear of swarf and left instructions that he must be transferred from this work. For reasons which he attributes to his poor sight, Mr. H.C. is now restricted to four operations only. He has asked the Disabled Persons Resettlement Officer to look out for alternative work. Mr. H.C. is married with no children, living an independent life in a rented council flat.

Mr. B.M. is now in his third job. Between jobs he has had long periods of unemployment. He appears to have been dismissed from his last job because of his lack of co-operation, combined with some aggressive behaviour. It is possible that the fundamental cause may have been his epilepsy. It seems probable that on one occasion he had hidden the fact that he suffered from epilepsy and after this trouble was revealed, he reacted angrily when his work was changed to less skilled occupations. Mr. B.M. has worked for a year in his present job which involves the use of capstan lathes.

Mr. D.M. is a taciturn, rather shy young man. No work had been found for him at the end of the assessment so D, helped by his father, applied directly for jobs. When I met him first in the course of my research he had been working for six years as a labourer in a small business where he was being paid only about £1.00 per week more than the sum to which he would have been entitled if he had been receiving routine Social Security allowances. Efforts had been made to persuade the boss to raise O's wages but the response had been of the nature of: "If you're dissatisfied, you know what to do!" The young man did not want to be unemployed. Mr. D.M. had not used the official placement services for disabled people and I suggested he should take the matter up with the local Social Welfare Officer for the Blind whom he and his parents know. He has now been employed for six months as a labourer by a wallpaper manufacturing firm, is a member of one of the Printers Unions and receives the correct rate for the job.

Mr. H.N. was not accepted for vocational training. At school he was a very practical boy, always wanting to help the gardeners and visiting workmen. Although gruff in voice and manner he seemed well liked by the people he helped. When he went home he had no official work at first but helped out unofficially on a building site. Then for two years he worked as a labourer on a pig farm and taking a fair amount of responsibility too. For the last three years he has been working as a hospital laundry porter, where he is one of a team of three porters who collect and deliver laundry for a group of hospitals that use a centralised laundry. Mr. H.N. was introduced to this work by his grandfather who was himself a hospital employee. I am assured by the superintendent of the hospital laundry that H. is well worth his pay and is a very effective worker.

Group 2. People in Sheltered Employment

I have seen 12 of these 13 people at work. The exception was Mrs. C.P. but I interviewed her at her home. I have also visited the homes of nine others.

Great changes are taking place in sheltered workshops for the blind. The skilled traditional crafts which required three or four year courses of training are being replaced by new occupations needing much less training and less skill. The new occupations vary from new industries using modern industrial machines and techniques to simple assembly and packing routines carried out mainly as outwork for local factories. It would, therefore, appear that employment for Condover ex-pupils in the newer workshops activities would be more feasible than in the former skilled crafts. Yet, many more ex-pupils, most of whom have at

least one handicap additional to their blindness, are employed in open rather than in sheltered employment. Inspection of the list of the occupations in Table 4.VII shows much the same type of job as the less-skilled work carried out by people in open industry. Why, therefore, are some ex-pupils in open employment and others in sheltered workshops? In presenting the statistics of Table 4.VII, and the subsequent case descriptions, I will attempt some explanations of the confusing situation by illustrations of personal experiences, and comments on some workshops where ex-pupils work.

In the introduction to this chapter I wrote about the proficiency level which is required as a qualification for admission to workshops for the blind. In the days of traditional crafts there was a fairly formal assessment of proficiency and the qualification was the ability to earn in a week approximately 25% of the wages of a sighted craft worker based on accepted trade union rates. Nowadays the position is not clear and the formality of assessment seems to have disappeared. It seems to be agreed in an unofficial fashion that the qualification level is of the order of 50% of the "normal earnings" for the job. Workers in sheltered workshops for the blind qualify for rates of pay linked with the rates for local authority manual workers, Group E.

Table 4.VII Some Personal Statistics: People in Sheltered Employment. N=13.

			Age	Home	Visual Handicap	Intellectual Handicap	Other Handicap	"Type"
Mrs.	C.P.	Packing	33	M	PS	Nil	-	P
Mr.	B.S.	Light Industry	28	H	B	Nil	-	P
Mr.	S.C.	Assembly/Packing	25	H	PB	Nil	c	V
Mr.	K.C.	Assembly/Packing	27	L	PS	Nil	b	P
Mr.	C.S.	Light Industry	30	M	PS	A	-	T
Mr.	B.C.	Assembly/Packing	29	P	PS	A	-	T
Miss	K.D.	Assembly/Packing	21	P	PS	A	D/B	V*
Mrs.	N.N.	Assembly/Packing	31	M	PB	A	-	T
Mr.	S.K.	Brush Making	37	I	PS	A	-	T
Mr.	F.G.	Porter/Stores	38	M	PS	A	a	T
Miss	E.S.	Home Worker	37	P	PB	A	-	P
Mr.	C.T.	Home Worker	36	L	PS	A	m	T
Mr.	B.E.	Porter	37	P	PB	A	-	X

Notes

The "Home" column code is:-

M : married, living in own home.
H : hostel.
L : in parents' home, but with many of the characteristics of a lodger.
I : living fairly independently in a rented flat.
P : in parents home, but with more protection than implied by L.

The "Type" column code is:-

P : promoted before school leaving age (with training afterwards).
T : had training in traditional craft.
V : attended vocational assessment courses.
X : not considered suitable for training.

Case Descriptions

(1) Eight people are employed in new-type occupations There are no special features concerning Mrs. C.P., Mrs. N.N., and Mr. B.C. They trained in traditional crafts and changed jobs when their Workshops undertook new lines of work. The cases of the other five people have a variety of points of interest.

Mr. B.S. is not multi-handicapped but needs sheltered rather than open employment. After promotion to a school for the blind there was a period of uncertainty and lack of occupation. Eventually he was accepted in a sheltered workshop where he did not complete a training in a traditional craft. The workshop has modified its activities in line with the modern trends. There are three departments:-

(i) a quite impressive plastic injection moulding factory where blind men tend the machinery and sighted employees do most of the inspection and packing. The management claim that this department needs no financial subsidy.

(ii) a light industry department, where as is usually the case in sheltered workshops, financial subsidy is necessary. Mr. B.S. works in this department as a good average worker, but he does not appear to have taken any official test of proficiency. He takes part in the department's main work — the production of wallets for the talking book cassettes. At one time the department produced steel knitting needles and B. had the reputation of being the department's best producer.

(iii) a basket making department, also needing financial subsidy. The workers here are mainly skilled, but elderly.

Mr. S.C. attended a vocational assessment course, where it was decided that he was suitable for sheltered employment rather than open industry, mainly because of his physical handicap. The nearest sheltered workshop is 50 miles from his home, but it has a hostel. S. was admitted to the workshop and the hostel. Although no formal test of proficiency was carried out he was found suitable for employment. An informal assessment of proficiency must take place since the manager told me of two physically handicapped sighted people who were admitted and found not to have sufficient ability to be retained. Unfortunately Mr. S.C. suffered a fractured leg while at work and recovery had been very slow because of S's history of brittle bones, a condition which, it was hoped, should have disappeared in early adulthood. He has been assured that, when he recovers, he will be very welcome at the workshop again.

Mr. K.C.'s history is rather complicated. He has a physical handicap and was promoted to a school which has a department for physically handicapped pupils and a department for partially sighted pupils. His behaviour handicap, which was noted at school, was accentuated when vocational training for brush-making began in a workshop for the blind. He found this too difficult a task which was not surprising in the least. After this training episode K. had a period of unemployment with considerable personal difficulties. He thinks that a period of rehabilitation at an R.N.I.B. establishment helped, as he said to me, "to straighten myself out". This improvement has continued because, I think, of the understanding treatment he has received in the small workshop for the blind which he has attended for the past six years. The workshop has changed from traditional crafts to assembly and packing. There has been no proficiency test for K, but he is the workshop's delegate to the local Trades and Labour Council. When I interviewed Mr. K.C. I found no indication of behaviour handicaps. I made these notes about his physical handicaps: "He is very mobile in walking, though he has a pronounced limp and finds some difficulties with unknown stairs and public buildings. One hand is so severely handicapped as to be nearly useless."

Mr. C.S. is doing more skilled and varied work than any other workers in the sheltered section of my enquiry, except those working in the traditional crafts. Apart from his lack of success in his efforts to read and write in both braille and inkprint he was one of our most capable pupils at school. On leaving school he spent four years training in basket making and reached the required standard of proficiency. He considers that these four years were wasted and he may well be right, but there have been some fortunate aspects of what, at first, seemed a failing career. When he started work as a basket maker, this craft was being phased out and, in any case, he had found the work difficult. The workshop has now, in effect, become a furniture making factory and C. was re-trained in divan making. He can now turn his hand to most aspects of divan manufacture, as well as the upholstery section, in which he was specially trained. He earns bonus payments of approximately 25% over the basic wage. It is possible that his difficulties with basket making plus his increased maturity when he came to the re-training, and the spur towards earning a living, were all contributory factors to his successful re-training. In other circumstances he might well have become a worker in open industry.

Miss K.D. is partially sighted and totally deaf and has been unable to establish any systemised method of communication. She is a very cheerful, pleasant young woman able to make clear easily her feelings and wishes. She attended a course of vocational assessment where it was thought she might be suitable for the nearby workshop for the blind, but she was transferred to the specialised occupation day centre for multi-handicapped blind people which is also nearby. The experience in the centre was beneficial and now she has been accepted into the sheltered workshop where she works well in assembly and is very well liked by staff and other workers because of her cheerful, helpful attitudes. The proficiency requirements here appear to be "the average production level of the other workers" which K. achieves.

(2) Four people are employed in the traditional sheltered occupations

Mr. S.K. has a physical handicap, which causes him to walk in an ungainly fashion. Nevertheless, he perseveres with walking and can, with much effort, manage a few miles. His hands are not seriously affected so I have rated the handicap as (a). After leaving school S. partially trained as a brush maker in Liverpool but employment there petered out. For a time, he worked as a brush maker at Leatherhead but he never really settled down there. Finally he came back North and has worked well for ten years in the workshop for the blind in Carlisle where there is a small but flourishing brush department. His parents died many years ago. He is unmarried and until recently he lived in 'digs' but a new development, initiated by the Workshop staff, has led to him renting a council flat with another employee of the workshop. I see no reason why, if the Workshop ever has to abandon brush making, Mr. S.K. should not succeed in any occupation which takes its place there.

Mr. F.G. works as a labourer-porter in a small workshop still carrying out traditional crafts, mat-making, basket work, and brush-making. He did not succeed in mastering any of these crafts. However, his present job is an important part of the workshop's activities and includes delivery of raw materials and collection of finished products to and from the workers, with some packing and branding.

Miss E.S. and Mr. C.T. are the only two Condover ex-pupils who work as blind Home Workers of the traditional type. It is very unlikely that any future visually handicapped school leavers, with or without additional handicaps, will take up this type of work. Miss E.S. has a machine knitwear business which she runs from a well-appointed workshop in the garden of her parents' home. Mr. C.T. has a basket-making business based on a workshop in his garden.

(3) One man, Mr. B.E., works as a porter in a workshop for the mentally handicapped, none of the other workers being visually handicapped. At school B. had a marked speech defect. His very clumsy hands were quite a serious hindrance, but I have not scored them as an actual physical handicap. We considered that he was not suitable for training in a traditional craft, which when he left school, was then the only form of training available. For some years he attended an A.T.C. for the mentally handicapped where he was intellectually more able than the majority of members. The sheltered workshop is in the same "campus" as the A.T.C. and I think there was an element of compassion in his "promotion" to his present job in which he cleans out toilets and outhouses, mows lawns, and does a few other simple jobs.

Group 3. Housewives

I have included in the 11 women in this group, two who have also been included in the Sheltered Employment section of this chapter. I have recently heard that one other woman has become married since the dead-line date after which I decided I would not change any details of my report. I have retained her, therefore, in Chapter 7. Nevertheless I include this newly married woman in my statement that only 12 former Condover girls have married and I will add a short postscript about her at the end of the case descriptions which follow Table 4.VIII.

Table 4.VIII. Some Personal Statistics (Married Women) N=11.

	Age	Visual Handicap	Intellect'l Handicap	Physical Handicap	"Type"	Husband's Vision	No. of Children	Home	Inde-pendence
Mrs.C.P.	33	PS	Nil	Nil	P	S	0	B	Yes
Mrs.S.D.	30	PS	Nil	Nil	P	S	1	R	Yes
Mrs.S.H.	35	B	Nil	Nil	P	PS	2	B	Yes
Mrs.N.W.	36	B	A	Nil	S	PB	2	B	Yes
Mrs.N.N.	31	PB	A	Nil	T	B	0	R	Yes
Mrs.C.D.	34	PS	A	Nil	T	B	2	R	Yes
Mrs.E.Y.	40	PB	A	Nil	R	S	3	R	Yes
Mrs.H.C.	32	PB	A	Nil	T	PB	1	R	?
Mrs.H.T.	39	PS	B	Nil	R	B	3	P	?
Mrs.T.E.	25	B	A	Nil	X	S	0	R	No
Mrs.J.B.	26	PB	Nil	C	X	S	0	R	No

Notes

(1) Column "Type" code is:-

P : promoted from Condover before school leaving age.
R : thought to be suitable for employment without training.
T : had course of training in traditional crafts.
X : thought to be unsuitable for employment.
S : special case, explained in case descriptions.

(2) Husband's vision. To the usual abbreviations for visual handicaps, I have added "S" to indicate normal vision.

(3) Of the 14 children, two are partially sighted, one of whom appears to have an intellectual handicap (A). One other child also appears to have an intellectual handicap (A), otherwise the rest seem to have no handicaps.

(4) Column "Home" code is:-

B : buying own home.
R : renting the home.
P : living with parent (widowed mother).

(5) Independence column. I use the term 'Independent' to mean that the housewife is so competent that, with the help of her husband, the household is independent of any organised help.

The comments "No" and "?" are explained in the case descriptions.

A general comment is that I found visits to the homes very pleasant. I visited all the homes, seeing all the ladies, all the husbands except two, and all the children except the three recent arrivals.

Case Descriptions

Mrs. C.P. and Mrs. S.D. are partially sighted and have sighted husbands. They live very normal lives and are really no longer handicapped at all.

Mrs. S.H. is comparable to the people working in open industry who have no intellectual handicap. She is not multi-handicapped. At school S. was partially sighted but her vision has deteriorated through partial blindness to blindness. In late adolescence she had a period of 'rebellion' which does not really amount to a behaviour handicap and may well be associated with declining vision. She didn't like the school to which she was promoted and removed herself from the vocational assessment centre. S. found herself some work in light industry later. Her partially sighted husband is employed in open industry and is a shop steward. Mrs. H. copes well with her household and family duties and is a good example of a blind housewife.

Mrs. N.W. was exceptionally able in countering the effects of her blindness. At that time I rated her intellectual handicap as (B), but she was amazingly good in mobility and practical work. In mobility, orientation and sensory compensation she is in the category I described in Chapter 2 comprising the few exceptionally gifted "natural" blind people. Although she had these good practical abilities, vocational training was deemed impossible yet we felt she could have worked well in a simple occupation not requiring training. This explains the "?" indication in the "Type" column. Unfortunately no work was found for N. and it was not until she was aged 29 that she attended an R.N.I.B. rehabilitation course. Here she met the partially blind man who became her husband. She has now found her true 'Métier'. She is a most effective housewife and mother. It is worth noting that a maturing process has taken place and Mrs. N.W. is no longer correctly assessed as (B) for intellectual handicap.

Mrs. N.N. was trained as an upholsterer in a workshop for the blind. This trade is no longer practised in her sheltered workshop, but she works in assembly and packing. Her blind husband works in the same workshop. Mrs. N. takes the responsibility for the housework, but her husband is an effective aide. When N. was at school her visual handicap was at the higher end of the partially blind category, but now she is nearly blind.

Mrs. C.D. had very frequent petit mal attacks every day while she was at school but these disappeared completely during late adolescence. The quite severe behaviour difficulties from which C. suffered declined and disappeared with the clearing up of the epilepsy. Her innate practical abilities became much more obvious. Now she is an effective housewife and mother requiring very little help from her blind husband.

Mrs. E.Y. was partially sighted at school and, after leaving school, she worked at Condover for a time as a dining room and kitchen maid, until she had to return home to help there. Now, her sight having deteriorated, she is partially blind and I gathered the impression that she is worried by the possibility of

further worsening of her vision. E's sighted husband, who is of about the same intellectual level as she is, has had periods of unemployment during which he has been very helpful at home. Mrs. E.Y., however, is very much responsible for household and family management. The Social Services Department are keeping a tactful watch on E's progress and will, I am sure, give her help if her sight should deteriorate further.

Mrs. H.C. worked for some years in a sheltered workshop before her marriage. She has had two bouts of depressive illness which necessitated hospital treatment as an in-patient. Although she is managing fairly well now as a housewife, I feel I cannot say that she is really independent. She receives no direct help but is supervised more closely by the Social Services than is the normal routine.

Mrs. H.T. has been separated from her husband for four years and she lives now with her widowed mother. Under the present conditions Mrs. H.T. can hardly be described as independent. Her mother is a dominant personality and H. acts very much as assistant. H. suffers from the after-effects of thrombosis though she is fairly active. Because of trouble with her eyes she has been advised to apply for registration on the Blind Register, so she may well now be partially blind instead of partially sighted. However, the situation is not as desperate as it may appear. Mother is a kindly person, H's three daughters are aged 11, 15 and 17. In another five years all the daughters should be independent or nearly so.

Mrs. T.E., when she left school, was not considered suitable for vocational assessment and employment. She is very ineffective in practical matters. After her marriage about a year ago she attended a course for blind housewives at an R.N.I.B. Rehabilitation Centre but gained very little from it. Her sighted husband manages most of the housework, as well as going out to work. He has had periods of instability of emotional behaviour in the past but, at present, his care of his wife has, in a way, a considerable rehabilitative effect on him. But how long will this last? Mrs. T.E. spends long hours during the day with little to do, though a neighbour gives some friendly help. T. says she would like to work, but her opinions about her work potential are quite unrealistic, and she refuses to attend a Day Occupation Centre. The Social Services Officer responsible for T. is well aware of the difficulties and has made many efforts to help.

Mrs. J.B. Although there are grave difficulties about J's situation because of her severe physical handicaps — she has an acute arthritic condition, which seriously affects the use of her hands and makes walking impossible — she has found a very satisfactory solution: marriage. Her husband is sighted but has a physical handicap which prevents him walking but he has good use of his hands. He is unemployed but is looking for work as a spot welder. He has been granted a four-seater car adapted for a disabled person's use and can, therefore, take his wife in it. The married couple have the assistance of a Home Help, Mr. B. is useful about the house and occasional help comes from relatives. Nevertheless Mrs. J.B. is very much the person who directs the household affairs. I was very much heartened to find this unusual but stimulating situation.

Post-script. Miss D.X. is described in Chapter 7. She is taking a course of study. Through this she met the blind man whom she has recently married. The couple are temporarily living with D's parents but they are looking for rented accommodation of their own.

Married Men Ex-pupils

To complete the picture of the married ex-pupils I give information about married men in the following table.

Table 4.IX Some Personal Statistics. (Married Men) N=12.

	Age	Visual Handicap	Intellectual Handicap	Wife's Vision	No. of Children	Home	Independence
Mr. E.Y.	39	PS	Nil	S	0	R	Yes
Mr. G.M.	38	PS	A	S	2	B	Yes
Mr. C.S.	30	PS	A	PS	2	R	Yes
Mr. F.G.	38	PS	A	S	0	R	Yes
Mr. D.S.	40	PB	Nil	S	2	B	Yes
Mr. H.C.	30	PB	A	S	0	R	Yes
Mr. S.M.	35	PB	A	PB	3	R	?
Mr. N.C.	30	PB	Nil	B	0	P	-
Mr. T.I.	28	B	Nil	S	1	B	Yes
Mr. C.R.	34	B	Nil	S	3	R	Yes
Mr. J.C.	37	B	Nil	S	1	B	Yes
Mr. B.Y.	37	B	Nil	S	2	B	Yes

Notes

(1) Reference to previous sections of this chapter will show that ten of the men who are now married, i.e. all except Messrs S.M. and N.C., went into work after promotion and subsequent training, training at school leaving age, or direct to work after leaving Condover. These ten men, with the help of their wives, nine of whom are sighted and one partially sighted, have established independent lives for their families.

(2) Mr. N.C., whose case is considered in Chapter 7, had an unhappy marriage. Things began to go wrong shortly after the wedding and he is separated from his wife.

(3) Mr. S.M. and his partially blind wife manage their home and family of three fairly well, but rely on Mrs. M's parents for some guidance and help.

Miscellaneous Information

(1) Mobility

I have accumulated statistics on the method of mobility aid used and the degree of mobility. For the degree of mobility I asked subjects to underline the statements which were true for them:-

(a) Walking (choice of one statement):-
I never walk alone outside home.
I can walk alone in the neighbourhood of home.
I can walk alone for at least two miles.

(b) Use of transport (no single choice asked for):-
I use trains or long distance buses quite independently.
I use local buses or tubes quite independently.

(c) Travel to work:-
I travel to work quite independently.

I have information about 53 of the 55 workers. The missing two are the woman who lives in a very isolated country area and a married woman who travels nearly always with her blind husband.

It is interesting to compare the statistics according to people's visual handicaps.

Use of Mobility Aids

13 blind people:- all use some kind of aid : three long cane, eight short cane, one guide dog, one sonic torch. The last two people use a short cane also. The man who uses the sonic torch is an enthusiast, its use amounting to a hobby. The high level of concentration necessary to interpret the clues afforded by the torch is illustrated by his remark to me, "If I want to be quick I use the torch but if I want to think, I use the cane."

16 partially blind people:- one long cane, eight short cane, seven no aid.

24 partially sighted people:- three long cane, three short cane, 18 no aid.

Degrees of Mobility

36 people claimed maximum mobility according to my schedule of statements, i.e. walking two miles and using long distance transport. According to visual handicap the 36 are divided thus:-

Eight blind people out of 13.
Nine partially blind people out of 16.
19 partially sighted people out of 24.

Since some people, especially those living in cities have no reason to walk long distances, and since long distance travel independently is not important for some people it is reasonable to consider local walking mobility plus the use of local transport as a good level of mobility. I have added the numbers of people with this degree of mobility to the statistics above, the total having increased to 45 people with good mobility:-

Eight blind people out of 13.
16 partially blind people out of 16.
21 partially sighted people out of 24.

This leaves only eight people to be accounted for:-

5 blind people : one is the deaf blind man, Mr. E.C., who only takes short local walks independently and uses a taxi for going to work; one is the dwarf, Mr. L.E., who, nevertheless is very effective in movement at work and at home; Mr. D.E. takes short local walks only, but travels to work with his father; Mr. O.Q. walks distances of at least two miles, but is taken by car to work; Mr. O.B. takes short local walks only and has a companion to and from work, but he is now taking lessons in mobility. None of these five uses public transport independently.

3 partially sighted people : one is the deaf-blind woman, Miss E.F., who takes local walks and uses certain selected 'buses; Miss T.B., who takes local walks only and does not use public transport independently, has a slightly physical handicap; Mr. Q.B. simply refuses to use public transport but walks very long distances at times.

Comment

I consider the mobility situation is very good. No people are less mobile than they were at school and most have improved considerably.

Mobility of the Nine Housewives who do not work

Mrs. P.B. is very seriously physically handicapped so the mobility enquiry does not concern her. The situation as far as housewives is concerned is somewhat complicated since they tend to travel all but short distances with their husbands.

I simply report that of the three partially sighted wives all are independent at the local transport and walking level. Two use no mobility aid and one uses a short cane.

Of the two partially blind wives one is independent for local walks only and the other is independent at the local transport and walking level. One uses a long cane, the other a short-cane.

Of the three blind wives, one is completely independent but the other two do not travel independently outside home. Two use a short cane, the other uses no aid.

(2) Literacy

This topic has been treated in the Interlude where I gave statistics concerning 42 people employed in open employment. Here I add information about the people in sheltered employment and housewives. I had no information concerning one partially blind person in sheltered employment, hence the total is 63. I have included the two people with intellectual handicap (B) in the statistics for intellectual handicap (A).

Table 4.X Literacy of 63 People.

Intellectual Handicap	Appropriate Medium		Use of Medium		
	Braille	Print	Most	Some	None
Nil. N=27	19		16	1	2
		8	0	6	2
(A). N=36	9		0	4	5
		27	0	9	18

The columns Braille and Print indicate the reading medium used by the readers or the medium which would have been used by non-readers.

The scores for Use of Medium are:- Most: reads at least six library books per year; Some: reads occasionally; None: no reading at all.

Comments

(1) The people discussed in this chapter would be expected to include a greater proportion of readers than in any of the other chapters.

(2) Of the 19 braille users who have no intellectual handicap, the two who do not read now, made some progress at school but have now abandoned braille.

(3) Of the nine braille users who have intellectual handicap (A), five make no use of braille, four of these made no progress in braille at school and the other person has abandoned braille.

(4) None of the print users made sufficient progress at school for me to expect that they would make much use of reading.

(5) Of the 20 non-readers who would use print, 16 made no progress in reading at school.

Talking Book

I have information about 55 people, four of whom are deaf-blind people who would not use this apparatus.

Only 13 people use the talking book, eight most days, two for two-three days per week and three occasionally.

(3) Leisure Time Interests

In the personal questionnaires which I issued to all ex-pupils, except those in hospital, there was a section on the use of leisure. This included a detailed set of questions concerning leisure interests at home and outside home. For home interests people were invited to score the frequency of their use of T.V., radio, gramophone records, tape-recorder, braille, talking book, print, telephone, household duties and typewriter. The frequency was on the scale of: Never; Occasionally; Two or three days per week; Most days. For outside home interests I asked people to choose between "I do go"; "I don't go but would like to go"; or "I don't want to go" for swimming, clubs, pubs, dancing, church, concerts, theatre, choir, evening classes and any other study. In addition people were asked to mention any other special interests or hobbies.

To make a detailed study would have taken more time than I had available. I can only present an overall impression, for which an introductory item of the leisure section of the questionnaire, is a useful aid. I asked people to underline the most appropriate statement thus:-

"As far as my leisure time is concerned:-
(1) I am satisfied with things as they are.
(2) While I am fairly satisfied, I would like a few more things to do.
(3) I am often bored and I would like to do a lot more in my spare time."

I received 57 completed questionnaires from the 64 people under discussion in this chapter. It was to be expected that people with a full work programme would also have a satisfactory leisure programme. 42 agreed with statement No. (1), ten with statement No. (2), and only five people stated that they were often bored. I was surprised to find that such a large number of people expressed satisfaction with things as they are.

I have already dealt with people's use of braille, print and the talking book. It is obvious that much use is made of radio, particularly by the blind. Most people also listen to the television but in most homes this is situated in the main living room and some listening is unavoidable. Approximately a quarter of the subjects listen to records on most days. About half of the subjects own a tape-recorder and for seven people its use amounts to a hobby.

As far as leisure-time activities outside home are concerned I will restrict myself to two topics: the mention of "I don't go, but would like to" and I will list some unusual hobbies.

From 1959, when the school swimming bath was opened, swimming became a very important activity. Very few ex-pupils who left before 1960 learned to swim but many who left after that date became very proficient. Ten people who can swim, no longer do so but would like the opportunity. At least 15 people go swimming.

Seven people would like to join a club, three would like to go to a pub, two would like to go dancing, eight would like to go to concerts or theatres.

Hobbies. Two partially sighted people enjoy water-colour painting and another one is a keen photographer. Two are frequent cinema-goers and another enjoys ice-skating. One partially sighted man and a partially blind man are gardeners and have small green-houses.

One partially sighted man plays outdoor bowls. Another does some sea fishing from a boat.

Two blind people are very active church workers. One blind man has a large collection of potted cacti. Three keep up their piano playing as a hobby. One has a remarkably well fitted wood-working shed where he produces many articles.

A partially blind man is very active in union affairs.

Summary and Comments

Employment

42 ex-pupils are in Open Employment. 20 have no intellectual handicap and 17 of these can be considered as being no longer multi-handicapped, any additional handicaps having disappeared during school, training or employment. The other three are exceptionally able deaf-blind people.

21 have a moderate intellectual handicap and one has a severe intellectual handicap.

13 ex-pupils are in Sheltered Employment. Two of these have no handicap additional to their visual defect. Of the 13, eight are employed in the "New" types of employment, four in traditional employment in workshops for the blind and one works in a sheltered workshop for the mentally handicapped.

Of the 55 people in employment 46 are men and nine are women.

Comments

(1) The first section of pupils, who had left by 1960, were more able than the more recently admitted pupils. The employment situation, as far as number of leavers going into employment is concerned, has not deteriorated. The admission of ex-pupils to Hethersett and Queen Alexandra College with subsequent help by placement officers has offset the decline in pupils' ability.

(2) The number of blind ex-pupils in employment is very low compared with those with some sight (partially blind and partially sighted).

Of 137 people in the blind category in the whole research survey, 12 are in open and one in sheltered employment. If the five blind people who were promoted before school leaving age are excluded, the number employed then becomes eight in open and none in sheltered.

Comparable figures for the other two grades of visual handicaps are:-

Of 102 partially blind people, 14 are in open and four in sheltered employment.
Of 75 partially sighted people, 16 are in open and eight in sheltered employment.

(3) The small number of ex-pupils in sheltered employment is due to the facts that the workshops only cover a part of the whole country, that few ex-pupils succeeded in training in the traditional crafts and that, although nowadays much less skilled occupations are available in the workshops, little or no pressure has yet been brought on managements to consider admitting visually handicapped people with additional handicaps, particularly intellectual handicaps.

(4) Although my comments so far have been confined to Condover ex-pupils, it has to be recognised that the number of visually handicapped school pupils with additional handicaps has increased considerably in the last ten years or so. Although no actual statistics are available schoolteachers are talking in terms of 50% of secondary modern blind school pupils having additional handicaps. Similar conditions exist in schools for the partially sighted and even if the estimate of 50% is reduced to 25%, the number of school leavers of this type is likely to be at least three times the number of present and future Condover leavers. Hopefully, most of these non-Condover based multi-handicapped adolescents will be of the type I have been discussing in this chapter and not many will be of the seriously handicapped type with which the main part of my report is concerned.

RECOMMENDATIONS FOR THE MULTI-HANDICAPPED BLIND

(1) The placement services should extend their existing help to include more aid to the additionally handicapped.

(2) Hethersett or Queen Alexandra College, or both, should consider extending their facilities or a completely new facility should be established to provide vocational assessment with actual vocational training in the simple forms of industrial skills for the less severely multi-handicapped school leavers (but see also the alternative (3) below).

(3) The development and organisation of sheltered workshops is currently being considered, based on the Consultative Document of the Department of Employment. I shall confine my remarks to the workshops for the blind and their relationship to the multi-handicapped blind.

An extract from the consultative document seems to sum up the situation admirably:-

"Sheltered Workshops should, according to the Piercy report, 'be available only to those who are willing to undertake the work provided and able to make a significant contribution to production'; while those who were capable only 'of a modicum of effort and industry' should have separate arrangements made for them. The report also strongly insisted that 'nothing could be worse than the prospect of a group of disabled people, some of them young on entering a workshop, remaining the whole of their working lives in a sheltered environment as a matter of course, and incidentally perhaps causing others with far better claims to sheltered work to be excluded."

I can understand that both managements, striving to achieve maximum financial returns thus reducing the costs on the community of the running expenses of the workshops, and the National League for the Blind and Disabled, which has fought hard and long for betterment of conditions and wages for workers in the workshops, do not wish to reduce standards of output. This tends to the exclusion of additionally handicapped applicants. However, with the increase of mildly multi-handicapped visually handicapped young people in mind, and their good claims for sheltered work instead of diversionary occupation, I suggest a third recommendation:-

Workshops for the Blind and Disabled should set up training departments or enclaves to give additionally handicapped young people experience and training in the simpler work activities of the workshops.

Recommendations for the Employment of the Handicapped Generally

(1) The quota of 3% disabled persons to be included compulsorily in work forces should be increased.

(2) Efforts should be made to add other designated occupations reserved for the handicapped extra to the present two — lift operators and car park attendants.

CHAPTER 5

DAY OCCUPATION CENTRES

Review of Contents of Chapter

The general situation concerning Adult Training Centres and Other Day Centres is reviewed briefly. This is followed by a brief statement concerning the placement of 87 Condover ex-pupils in the different types of centres. Since A.T.C.'s are concerned with mentally handicapped people and Other Day Centres presumably exclude them, Table 5.I examines the distribution of ex-pupils between the types of centres in the light of their handicap.

The definitions of mental handicap, based on the Mental Health Act of 1959, are discussed as a preliminary to a lengthy examination of the validity of the placement of ex-pupils in centres for the mentally handicapped, where there are very few visually handicapped among many sighted people.

Section (A) deals with 60 ex-pupils in A.T.C.'s. Some information concerning the services provided by the A.T.C.'s is given and an attempt is made to assess the staff's treatment of the visual handicaps of the ex-pupils who attend these centres. This ends with Table 5.VI, which is based on pay scales of A.T.C.'s, and is used as a basis for the subsequent examination of individual cases. This examination is based upon tables of personal statistics and individual case descriptions. The broad assumption is made that 36 people rated as (B) and (C) for intellectual handicap are correctly placed in A.T.C.'s, but more detailed assessment is made of 24 cases of people with no intellectual handicap or with handicap (A). Special emphasis is laid on those people who have no sight.

Section (B) deals with 27 pupils who are placed in a variety of Other Day Centres. The enquiry here high-lights the cases of people who were, at one time, considered possible candidates for employment. Also some consideration is given to people who have intellectual handicaps (B) equivalent to many people attending A.T.C.'s.

There follows a description of the only day centre specialising in multi-handicapped blind adults, which has developed a service with links with hospitals, rehabilitation services and a sheltered workshop.

A brief section of miscellaneous information includes an important statement concerning mobility. The chapter ends with a summary, commentary and recommendations.

Day Centres

My research into the present circumstances of former Condover pupils have led me to an investigation of a special section of the system of day centres, i.e. only those centres who have admitted one or more of the people who are the subjects of the research. It has become evident that, as far as day centre placement of ex-Condover pupils is concerned, the most significant contribution is being made — certainly quantitatively and possibly qualitatively — by the Adult Training Centres for the Mentally Handicapped who have no specific responsibilities for blind people. I will examine the figures in more detail later, but basically 60 ex-pupils attend A.T.C.'s and 27 attend a variety of Other Day Centres, in some of which specialisation for the blind is provided. I shall use this phrase 'Other Day Centres', although it is not an official term, to distinguish them from the A.T.C.'s. The fundamental difference is that the Other Day Centres deal with people with handicaps other than mental handicaps, whereas the A.T.C.'s are

for mentally handicapped people. In the terms of my research survey, the vital issue is: in which type of centre should intellectually handicapped blind people be placed?

In order that I may give a reasonably well-balanced account of the situation, it is important to set the Condover statistics against the national background of the provision of day centres. I will give a brief historical summary, plus some figures concerning the provision of day centres at the beginning of 1972. I have gathered this information from the Report of the Working Group on the Training Needs of Staff in Day Centres (1972). From this report I reprint paragraph three which gives a résumé of the statutory situation:-

"Local Authority day centre services are at present provided under the terms of the National Assistance Act 1948, and the Health Services and Public Health Act 1968 (for the elderly and mentally disordered). Mandatory Services for blind people were started under the Blind Persons Act 1920 and Local Authorities have also had special responsibilities for the mentally handicapped since 1913; but until the National Assistance Act, community services for most handicapped persons were provided under the Poor Law, supplemented by the work of voluntary bodies. Schemes made under the 1948 National Assistance Act empowered local authorities to promote the welfare of the blind, deaf, or dumb or other persons substantially and permanently handicapped by illness, injury or congenital deformity. Authorities could make arrangements for such persons to receive instruction in their own homes or elsewhere in methods of overcoming the effects of their disabilities; they were also empowered to provide workshop and recreational facilities. The making of schemes, except for the blind, was, however, not made mandatory until 1960. After the 1959 Mental Health Act, provision of the care and after-care services for the mentally disordered also became a duty. The Local Authority Social Services Act 1970 required local authorities to set up Social Services Committees to which certain statutory powers and duties, including those for day centres were to be referred."

The Working Group considered that the development of Other Day Centres services has been both slow and uneven, a statement with which I certainly agree. I add that the situation with regard to the multi-handicapped is far from clear, a subject to which I will return later. My pleasure and relief that so many former Condover pupils, who previously would have been unoccupied, have found placements in day centres during the past ten years or so should not lead to facile feelings of satisfaction, since rather more than two thirds of the placements have been in Centres for the Mentally Handicapped. Much remains to be done in the general sphere of day centre provision and in the special area of multi-handicapped blind people.

Other Day Centres

The Working Group Report gives the following figures for 1972 for local authority day centres other than those for the mentally handicapped. The total of 562 Other Day Centres was made up of:-

(i) 104 centres for physically handicapped persons aged under 65. Of these centres 81 had less than 50 places and 41 were open for less than 30 hours per week.

(ii) 207 centres for physically handicapped persons and elderly persons combined. Of these centres 133 had less than 50 places and 109 were open for less than 30 hours per week.

(iii) 157 centres for elderly people only. Of these, 108 had less than 50 places, and 23 were open for less than 30 hours per week.

The total staff for centres of types (i) to (iii) was 507 full-time and 376 part-time, excluding manual, domestic and clerical workers.

(iv) 73 centres for the mentally ill. Of these, 63 had less than 50 places and 16 were open less than five days per week (173 full-time and 25 part-time staff).

(v) 21 mixed centres. Of these, 11 have less than 50 places and four are open less than five days per week (43 full-time and 26 part-time staff).

N.B. The term "physically handicapped", as used here, is a global description which can cover blindness as well as crippling defects. Some of the centres for physically handicapped persons and elderly persons combined have, no doubt, developed from centres established previously for the welfare of blind people.

The Working Group Report recommends the setting up of training courses for staff as a matter of extreme urgency. References are made to the "much greater development" of the system of Adult Training Centres for Mentally Handicapped Adults and the training courses for teachers in these establishments.

Adult Training Centres for the Mentally Handicapped

The Department of Health and Social Security statistics for 1973 show that, at March 1973, there were 367 A.T.C.'s with places for 29,725 members. The number of staff at September that year was 2,996. Training Courses for teachers started in 1964, and, by 1972, the Training Council responsible had awarded 800 diplomas to successful trainees. No doubt this training scheme and the associated feeling of the staff that they are part of a developing service is one explanation of the fact that I found my visits to Adult Training Centres so interesting and stimulating. The Ministry of Health's short pamphlet "A Model of Good Practice" (1968) must have been very helpful in fostering feelings of professional pride in work for mentally handicapped adults. A further encouraging publication is a pamphlet of August 1972 in which the Training Council discusses the organisation and content of a one-year course for teachers, showing that developments are being actively pursued.

Condover Ex-pupils in Day Centres

A few ex-pupils who attend day centres for a maximum of two days per week are mentioned in Chapter 7 (At Home). The present chapter deals with people who attend centres for what can be described as "most of the working week". Attendance for such a lengthy period has some obvious advantages. To the handicapped people it gives the feeling of attending work and there are the satisfactions derived from companionship and interest in the activities of the centre, with an associated reduction in boredom. In addition there are the very real benefits to the families of the handicapped people in that the daytime responsibility becomes very much lighter and, if she wishes, the mother can go out to work.

87 ex-pupils are considered as suitable for discussion in this chapter, i.e. 28% of the whole research group of 314. Of the 87 people, 79 attend their centres five days per week. For ease of treatment and for interest of comparison the 87 subjects will be subdivided into two main groups:- (a) 60 people who attend Adult Training Centres for the Mentally Handicapped and (b) 21 people who attend Other Day Centres. In addition I shall add information about two very small, special groups, each of three people, one group attending the country's only day centre for multi-handicapped blind people, the other attending Occupational Therapy Units or Industrial Training Units of Hospitals for the Mentally Handicapped as day patients.

Only two of the 60 people at A.T.C.'s do not attend five days per week. One man attends three days per week but has other interests for the other days. Another man, who attends four days per week, suffers from asthma and the relief he receives by taking a three-day week-end makes it possible to manage the other four days in reasonable comfort.

Six people of the 21 at Other Day Centres do not spend five days per week there. Two men and one woman spend four days per week, the two men being unable to go on the fifth day because of pressure on places in the centre, while the woman stays at home one day to help her mother with household duties. One man and one woman attend three days per week, the woman having some interests on the other days, while the man has only recently started attending his centre after having passed at least five years previously at home with very little to do and there is a distinct possibility that he will shortly spend more time at his centre. One woman attends only two days per week and I had to decide whether she should be included in Chapter 7 or in the present chapter. I decided on the latter because she carries on at home very effectively the craft work which she performs at her centre. Although she is physically handicapped she is capable in simple housework and can safely — and happily — be left alone when necessary. I decided, therefore, to treat all the 87 as full-time at day centres.

Mental Handicap

The topic of mental handicap is vital to the discussions of this chapter. Many parents are reluctant to have their sons and daughters classified as "mental" or to allow them to attend "places for the mental". It is unfortunate, but understandable, that there is a very common feeling of repugnance to the idea of mental handicap and it is important, therefore, that I should discuss the matter in some detail.

The Mental Health Act of 1959

This Act replaced previous Mental Deficiency Acts and abolished the term "mental deficiency" and the associated definitions of "idiot", "imbecile", "feeble-minded", and "moral defective". The new Act introduced instead the concepts of "mental subnormality" and "psychopatic disorder", defining them thus:-

Section 4 (2).... 'severe subnormality' means a state of arrested or incomplete development of mind, which includes subnormality of intelligence, and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so.

Section 4 (3).... 'subnormality' means a state of arrested or incomplete development of mind (not amounting to 'severe subnormality') which includes subnormality of intelligence, and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.

Section 4 (4).... 'psychopathic disorder' is a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment.

In discussing the topic of mental handicap I have found the introductory pages of a book by W. Alan Heaton-Watson very helpful (Mental Subnormality, 1961). With reference to the above definitions, the author comments (page 11):- "While recognising that 'mind' is something more than intelligence alone, embracing as it does such other facets of an individual as personality and character and temperament, the definition makes it clear that a person is not to be considered mentally subnormal merely because he shows defects of these other facets unless he is, in addition, subnormal in intelligence to the varying degrees defined."

It was interesting to note that Heaton-Ward considers that the Act wisely did not distinguish between subnormality and severe subnormality in terms of I.Q. He points out that the criterion of severe subnormality is a social one, namely the incapacity for independent living or for protecting oneself against serious exploitation. Although the criterion of subnormality is less clearly defined, he comments that subnormality can imply the ability for independent living and he stresses the wording of the Act: 'of such a nature to require or be susceptible to medical or other training'. He states further (page 12) that the category of subnormality "would appear to include many people on the indefinite borderline of normal intelligence, who constitute a large proportion of the social problem group, whose disabilities are manifest in general inefficiency and inadequacy rather than in the persistent abnormally aggressive or seriously irresponsible conduct which are the criteria of psychopathic disorder".

There is a general tendency nowadays to replace the terms 'subnormality' and 'severe subnormality' with 'mental handicap' and 'severe mental handicap'. I propose to use the description 'mental handicap' when I wish to refer to the general condition, otherwise I shall continue to use the more specifically described handicaps as used throughout my research.

Relevance of Handicaps as Defined in the Research to Mental Handicap

There are obvious similarities between my definitions of intellectual and behavioural handicaps and the Act's concepts of subnormality and psychopathic disorder. My category of intellectual handicap (C) is approximately equivalent to severe subnormality which could also include the lower range of my category (B). Category (B), on the whole, would appear to be equivalent to subnormality which could also include the lower range of category (A). My category (M) for behaviour handicaps includes some people who might be classified as having a psychopathic disorder though this would not apply to other people of category (M) and all people in category (m).

With Condover ex-pupils, apart from their intellectual and behaviour handicaps, the situation is complicated because all have a visual handicap and some have other handicaps as well. The multiple nature of many people's handicaps certainly makes a contribution to their incapacity for independent living and for guarding themselves from serious exploitation. This applies to a number of ex-pupils with intellectual handicap (A) and a few with normal intelligence, especially when they have poor employment potential. To what extent, therefore, should multi-handicapped blind people be considered as being mentally handicapped? The remainder of this chapter is mainly concerned with a discussion of this question.

Placement in A.T.C.'s or Other Day Centres

Although the number of Condover ex-pupils in this research is comparatively small, it must be remembered that there are other multi-handicapped blind adults. Also there is a steady flow of Condover school leavers of about 20 per year, the majority of whom will be candidates for admission to day centres, as well as some additionally handicapped school leavers from schools for 'normal' visually handicapped children. In addition there are other types of multi-handicapped people besides the multi-handicapped blind. Condover ex-pupils are only a part of a large number of multi-handicapped people, many of whom have intellectual and behaviour handicaps and it seems to me that a broad decision is necessary as to whether they also need placement in A.T.C.'s because of a 'mental' handicap or in an Other Day Centre because of their 'physical' handicap.

Availability of Centres

Earlier in the chapter I have emphasised that the development of A.T.C.'s is much greater than that of Other Day Centres. For almost all of the 60 ex-pupils attending A.T.C.'s, there was no alternative choice of an Other Day Centre. On the other hand, for most of the 21 people attending Other Day Centres (this number excludes the two small special groups of three people in each) the alternative of an A.T.C. was available.

Table 5.I is a preliminary exercise in comparing the suitability of A.T.C.'s and Other Day Centres for Condover ex-pupils. Accurate comparisons are not statistically reliable because of the small numbers concerned, especially when it is remembered that, of the 21 people in Other Day Centres, ten are in Centres for the Physically Handicapped and 11 in Centres for the Blind and Physically Handicapped; nevertheless, some interesting and important facts arise. (The two small special groups have been excluded from the table, but they will be discussed towards the end of the chapter.)

Table 5.I A.T.C.'s, Other Centres and Whole Research Group: Handicaps Compared. N=81

		All Centres (81)		A.T.C.s (60)		Others (21)		Whole Group (314)	
		No.	%	No.	%	No.	%	No.	%
Sex	M	53	65	40	67	13	62	190	61
	F	28	35	20	33	8	38	124	39
Vision	PS	8	22	15	25	3	14	75	24
	PB	26	32	20	33	6	29	102	32
	B	37	46	25	42	12	57	137	44
Intellectual Handicap	Nil	9	11	3	5	6	29	61	19
	A	32	40	21	35	11	52	129	41
	B	32	40	28	47	4	19	82	26
	C	8	10	8	13	0	0	42	13
Physical Handicap	Nil	53	65	41	68	12	57	220	70
	a	7	9	5	8	2	10	31	10
	b	15	19	11	18	4	19	36	11
	c	6	7	3	5	3	14	27	9
Behaviour Handicap	Nil	54	67	36	60	18	86	207	66
	M	21	26	18	30	3	14	68	22
	m	6	7	6	10	0	0	39	12
Deafness	Nil	71	88	51	85	20	95	270	86
	d	7	9	6	10	1	5	20	6
	D/B	3	4	3	5	0	0	24	8
Epilepsy	-	19	24	15	25	4	19	65	21
Promoted	-	2	3	1	2	1	5	27	9
Discharged	-	6	7	5	8	1	5	45	14
Occupation Estimate	i	0	0	0	0	0	0	43	14
	ii	16	20	8	13	8	38	73	23
	iii	32	40	23	38	9	43	81	26
	iv	26	32	24	40	2	10	67	21
	v	7	9	15	8	2	10	50	16

N.B. Discussion of the scoring system for handicaps will be found in Chapter 1, with a summary on page 24. For convenience, a bookmarker with a copy of the summary is provided.

Comments

(1) The column for the whole research group is given for reference. Its comparison with the other columns reveals no unexpected facts, but the distribution of handicaps confirms that the people in the combined Day Centres are a "middle group" of the Whole Research Group, i.e. less the employed people and those in hospital.

(2) Although the number of people in Other Day Centres is small, comparison of the numbers in this column with those of the A.T.C.'s gives some interesting information:-

Intellectual Handicaps One would expect intellectual handicaps to have a higher incidence of severity in the A.T.C. group than in the Other Centre group and this is shown thus:-

(i) all eight people of handicap (C) are in A.T.C.'s;
(ii) apart from four people of handicap (B), all the people in Other Centres have either handicap (A) or no intellectual handicap.

I draw attention to the fact that 24 of the people in A.T.C.'s, i.e. 40%, have handicap (A) or none, which is important for my discussion.

Physical Handicaps The presence of these handicaps in Other Centres was to be expected. The fact that approximately one third of the people in A.T.C.'s have a physical handicap confirms my impression that a great variety of severely handicapped people are accepted in these centres.

Behaviour Handicaps The high proportion of people in A.T.C.'s with behaviour handicaps and the small proportion of such people in Other Centres is due to the connection of these handicaps with mental handicap.

SECTION (A):- 60 CONDOVER EX-PUPILS IN A.T.C.'S

In Section (A) I shall consider people who are in A.T.C.'s, dealing with people in all other day centres in Section (B), beginning on page 134.

The 60 former Condover pupils who are now in A.T.C.'s are distributed between 54 centres, one centre taking three, four centres taking two each, and forty-nine centres taking one each. I have visited 48 of these centres. Questionnaires, which have been used for amplification and up-dating of the information which I gathered on my visits, have been sent to all these centres. Copies have also been sent to five other centres which I did not visit. One centre has received neither a visit nor a questionnaire because the ex-Condover pupil concerned began to attend her centre just at the dead-line I had set myself for the completion of information gathering. All centres returned the questionnaires but the staff of a few centres did not complete all its sections. Altogether, therefore, my discussion of A.T.C.'s is based on 53 centres:- 48 centres visited, with supporting questionnaires; 5 centres which were not visited but from which well-completed questionnaires were received.

Personal Comments and Opinions

I infer that the presence of the word training in the title of Adult Training Centres arises from the Mental Health Act of 1959, which led to the founding of the system of A.T.C.'s when it was expected that an important feature would be that a reasonably large proportion of the 'trainees' would move on to

employment under supervision, or even independently. I have seen no figures concerning the number of trainees who have gained employment in this fashion, but, from conversations with staffs of A.T.C.'s, I gather that successful employment placements are no higher than 5%.

There appears to have been considerable changes in aims and objectives for A.T.C.'s from, say, 1970 onwards. An anecdote will help to make this topic clear. In early 1971, I visited an A.T.C. before I began my Condover research. In conversation the manager of this centre emphasised to me that his was a training centre and he was not going to admit "people who sat around on their behinds all day doing nothing". If this attitude had been general, the admission of some multi-handicapped blind people to A.T.C.'s would have appeared doubtful. Fortunately, most centres now admit people with a considerable variety of severe handicaps, including some who cannot really be considered to be mentally or intellectually handicapped but who have other grave handicaps which constitute a severe occupational handicap. I very much welcome the present policy concerning A.T.C.'s, especially as it has led to the acceptance in these centres of former Condover pupils, and of other severely multi-handicapped people. Nevertheless, I support whole-heartedly the desire of staffs of the centres that transfer employment of some more able members should continue to be one of their aims.

Services Provided by A.T.C.'s

I have found my visits to A.T.C.'s most enjoyable and encouraging. Attitudes and practices obviously vary from centre to centre, owing to variations in the aims and ideals of the staffs. Taking the service as a whole, at least as far as I have seen it, I consider that there are three main types of provisions made for members:- Occupation, "Further" Education, and Social Experiences. There is considerable overlap among these areas of activity, but it is worth while discussing developments under the separate headings.

Work/Occupation

One important benefit gained from the "training" aspect of the centres is the very positive and practical attitudes to the provision of occupation and the great variety of activities which have been developed. There has been a decline in the use of the traditional crafts of knitting, basketwork, stool-seating, etc., in favour of newer developments, though some craft work still takes place, often with simplification and modification of materials, methods, and products, to suit handicapped people. Ingenuity in modifying methods, devising jigs, using simple machinery etc., to break down jobs into a series of simple operations, is apparent in nearly all A.T.C.'s, much helped by the fact that many men and women with experience in industry are now employed as instructors in A.T.C.'s. Nearly all centres rely on a considerable amount of contract work, mostly packing, inspection, and assembly, obtained from local industries. Several centres have developed their own minor production projects involving carpentry, concrete production, gardening, small commercial-type laundry services, etc.

The general impressions left upon me are of interested, ingenious staff working for the benefit of groups of gainfully occupied severely handicapped people and producing a sense of purpose within the centres. Naturally, things do go a little wrong and improvements are possible. For instance, sometimes there are frustrating periods when the supply of work peters out and the atmosphere of self-disciplined occupation tends to deteriorate. Suitable work can be quite difficult to find. Managers of centres have to spend much time searching for work from neighbouring firms and I think they must wish that there were some agreed plan for reserving certain types of work for A.T.C.'s.

In all the centres which Condover ex-pupils attend, with one exception, there exists for the trainees the pleasant, personality-boosting system of some payment for their work. Although the maximum permitted weekly earnings, without deductions having to be made from Social Security Allowances, are only £2.00 per week — and many trainees get less than this — the idea of wages for work and the weekly pay packet has beneficial effects on the members.

Further Education

It is obvious that, in the context of the very handicapped people who attend A.T.C.'s the concept of Further Education has a special meaning. Schemes of this nature have not been developed in all centres, but I have seen many programmes of practical, realistic education, and there seem many indications that the idea of further education will spread. I have been much impressed by the fact that many ex-Condover pupils have continued to progress "intellectually", confirming the impression often expressed by Condover staff that when some pupils reached school leaving age they were becoming more receptive for education. It has been, therefore, most interesting and reassuring to see how the staffs of some A.T.C.'s are helping their trainees to continue their education, taking advantage of the maturing processes which are still going on after childhood and adolescence.

Many centres run remedial courses in reading, writing, and arithmetic based on practical life situations for their trainees. Some of these schemes resemble, in some ways, the practices of primary education. Many types of housecraft are taught; in some cases the schemes are aimed at the acquiring of a kind of "survival kit of skills" which would aid independent living. Domestic-sized kitchens and living rooms are sometimes contrived within centres so that instruction can be practical and, as it were, life-sized. I have seen Current Affairs schemes, some Environmental Study, simple Human Biology, etc., and evidence of educational outings.

Obviously no single centre has a scheme incorporating all the above activities, though a few centres approach this state, but I have the impression that the A.T.C. service, as a whole, is making invigorating progress moves towards a special service of further education.

Social Experiences

I have coined this phrase to describe the kind of activities which some A.T.C.'s promote. I am thinking of a wide variety of topics: Open Days, Sports Meetings, Day Outings, etc. Many centres organise club activities in evenings, some arrange quite ambitious summer holidays. Another type of activity may or may not involve trainees, but some centres have instituted Parent-Staff meetings, Friends of the Centre organisations, etc.

General Statistics concerning A.T.C.'s Questionnaires were sent in 1974 to 53 centres and elicited the following information:-

(1) Numbers of members in Centres.
48 centres supplied information:- total members: 4,366, of whom 54 were 'Condovers'.
Only 41 centres gave information about other blind members:- total members: 3,805, of whom 47 were 'Condovers' and there were 66 other blind members.

(2) The ratio of blind members to total members is 1:34, the range varying from 1:11 to 1:113.

(3) All centres organise transport for members' travel between centre and home. Only one centre makes any charge.

(4) All centres provide mid-day meals. 17 make no charge; one gave no information; 35 make a charge, the average being 54p per week and the range from 30p to 90p.

(5) 52 centres operate pay schemes, one does not.

(6) 49 centres provide an education scheme, four do not. 44 'Condovers' take some part.

(7) 31 centres have associated organisations of Parents, Friends, etc; 19 do not. Three centres did not reply.

(8) 50 centres organise day outings and holidays, including 31 with summer holiday schemes of at least one week. Three centres do not.

(9) 32 centres organise clubs, 20 do not. No information concerning one centre. Distance from home to centre, availability of transport, and personal choice affect attendance. 32 Condovers could attend a club: 15 do not; 7 take a full part, 10 take a not very active part.

Staff without Specialised Training Dealing With Visually Handicapped Members

Although some staff expressed diffidence about their lack of training with visually handicapped people, especially the blind, my general impression was that Condover ex-pupils have been very well received by staff and members of centres. I felt, however, that I should try to obtain an objective assessment of the integration of ex-pupils into the centres, so part of the staff questionnaire which I circulated was formulated with this aim in mind. Staff were asked to estimate ex-pupils' vision and to evaluate their work performance, though I had to rely on general descriptions rather than precise measurements. I hoped that the examination of each ex-pupil's weekly pay and its relation to the centre's pay scale, might prove revealing.

(a) Staff Estimates of Ex-pupils' Vision (59 replies received)

The objective of this exercise was to discover if staff, who had little or no experience of visual handicap, were making important errors of judgements of visual handicap. Staff were asked to estimate vision of ex-pupils in the following terms:-

(a) so good that one can forget that vision is defective	3
(b) vision useful for most purposes	9
(c) some useful vision for a restricted number of purposes	18
(d) only a very little vision which is not very useful	7
(e) totally blind	22

The staff scores of (a) and (b), are equivalent to my grade 'partial sight', (c) and (d) are equivalent to 'partial blindness', and (e) is equivalent to 'blindness'.

Comparison of staff estimates and mine can be summarised thus:-

Partial sight	Staff : 12;	Mine : 14.
Partial blindness	Staff : 24;	Mine : 20.
Blindness	Staff : 22;	Mine : 25.

The differences between staff estimates and mine which seem, from the summary, to be reasonably small, are more numerous when individual cases are examined, owing to the self-cancelling changes which take place in the summarising process.

Comments

(1) Three people described by me as blind were scored (d) by staff. This is due to my definition of blindness which includes very small amounts of residual vision. Hence there is no real discrepancy here. In fact the difference shows good observation by the staff concerned.

(2) Six people described by me as partially sighted were scored by staff as (c). In three cases this is probably simply a matter of borderline decisions between good partial blindness and poor partial sight. In three cases, however, I suspect that staff were underestimating the individual's vision, two of the people concerned being non-communicating deaf, where assessment poses considerable difficulty.

(3) Four people described by me as partially blind were scored by staff as (b). All these were borderline decisions between partial blindness and partial sight and the discrepancy has little or no significance. It is interesting to note that in three cases the visual handicap is the after-math of some form of cerebral illness when the accurate estimating of visual acuity is particularly difficult, while the fourth person was transferred to Condover at the age of 15 from a school for the partially sighted for a period of social education.

(4) One person described by me as partially blind was scored by staff as (a). I have no explanation of this discrepancy and am inclined to accept the staff's estimate as being more accurate than mine since the young man concerned, who had marked behaviour problems at school, is conforming quite well to the pattern of life in his centre.

(5) It seems, therefore, that as far as awareness of degree of visual acuity, is concerned the staffs of A.T.C.'s are making no very serious errors of judgment.

(b) Visual Handicap and Occupational Performance

The staffs of the centres were asked to score their ex-Condover pupils on a five-point scale, comparing them with the "average trainee" in three aspects of occupational performance. These were:-

General Standard of Work:- (A) - "Borderline" for employment; (B) - Above average; (C) - Average; (D) - Below average; (E) - Diversionary pursuits only.

Speed of Work:- (A) - Exceptionally good; (B) - Above average; (C) - Average; (D) - Below average; (E) - Exceptionally slow.

Range of Work:- (A) - Full range; (B) - Above average; (C) - Average; (D) - Below average; (E) - Exceptionally restricted.

Table 5.II Visual Handicap and Occupational Performance. N=59.

Visual Handicap	General						Speed						Range					
	A	B	C	D	E	Mean	A	B	C	D	E	Mean	A	B	C	D	E	Mean
PS (14)	0	1	10	3	0	2.9	0	1	9	2	2	2.6	0	2	7	5	0	2.8
PB (20)	0	3	6	8	2	2.5	2	0	11	3	4	2.6	1	3	5	10	1	2.6
B (25)	0	5	10	5	5	2.6	0	6	7	9	3	2.5	0	2	5	13	4	2.2
Totals	0	9	26	16	7	2.6	2	7	27	14	9	2.6	1	7	17	28	5	2.5

Notes: For one partially blind person no score was given for General Standard and for one blind person no score was given for Range of Work.

The means were calculated by assigning scores of one to five for grades (E) to (A) respectively.

Comments

(1) The mean scores all lie between 2.2 and 2.9, i.e. between (D)=2 meaning "below average", and (C)=3 meaning "average".

(2) The mean scores for the partially sighted were higher than those for the partially blind and the blind, which was to be expected. The mean scores of the partially blind and the blind were very similar except for the low score of 2.2 for Range of Work. This low score was to be expected since some of the work in the centres, involving colour and very small sized objects is difficult or impossible for blind people.

(3) I was somewhat surprised:-

(a) that there were so few scores of (E);
(b) that the variation between partially sighted and blind was so small;
(c) that the mean scores for the blind lay almost midway between average and below average: I was expecting a lower score.

(c) Staff Opinions on Effect if Visual Handicap

For each of the estimates made of occupational performance I asked staff to state which of the following statements was appropriate to the person with whom they were dealing:-

"If this person had normal vision do you consider he would do: (a) much better? (b) a little better? (c) no better?"

Table 5.III Staff Opinions on Effect of Visual Handicap. N=59.

Visual Handicap	General				Speed				Range			
	a	b	c	Mean	a	b	c	Mean	a	b	c	Mean
PS (14)	4	7	3	2.1	5	5	4	2.1	6	4	4	2.1
PB (20)	11	6	2	2.4	9	8	3	2.3	12	8	0	2.6
B (25)	19	6	0	2.8	16	9	0	2.6	18	6	0	2.7
Totals	34	19	5	2.5	30	22	7	2.4	36	18	4	2.5

Notes: One partially blind person had no score for General Standard and one blind person had no score for Range of Work.

Mean scores were calculated by assigning scores of one to three to grades (c) to (a) respectively.

Comments

The mean scores for the partially sighted are very close to (2), equivalent to "would do a little better". The mean scores for the partially blind are approximately between "would do a little better" and "would do much better". The mean scores for the blind are nearer "would do much better".

(d) Pay Scales

As many A.T.C.'s operate graded payment scales, it appeared to me that examination of these scales might help to counteract the vague definitions on which Tables 5.III and 5.IV were based and might give a more objective indication

of the effectiveness of Condover ex-pupils in A.T.C.'s. 53 centres were asked for details of their pay schemes, and were asked to add the actual amounts paid to Condover ex-pupils.

Three centres supplied an individual's payment but gave no details of the scheme; one centre does not operate a scheme, but hopes to develop one soon, while one centre was just starting a scheme at the time of my last enquiry. Three centres pay a standard rate per week to all their members: one pays £2.00, one pays 75p, and the other pays 50p. One centre distributes profits on craft articles sold.

This leaves 44 centres who operate a scale and who gave information about ex-pupils' payment. The range of scales is wide and the factors affecting an individual's position on a scale vary from centre to centre and include attendance money, payments for production, effort and good behaviour.

Although the ceiling weekly payment for earnings for people receiving Social Security allowances is £2.00, one centre has a scale from 50p to £2.50, one from 25p to £2.25, and another from 85p to £2.05. By far the most frequent maximum is £2.00, 25 centres paying this amount, the most popular scale being 50p-£2.00, paid by 12 centres. The starting points for the other 13 vary from 0p-£1.00 (one centre at 0p, three at 10p, one at 25p, two at 30p, one each at 60p, and 68p and two each at 75p and £1.00). With one exception all the other 16 centres operate different scales which are:-

25p-£1.90; 80p-£1.80; 40p-£1.50; 60p-£1.50; 75p-£1.50; 40p-£1.45; 20p-£1.40; 25p-£1.25; 50p-£1.25(two centres); 60p-£1.25; 10p-£1.00; 50p-£1.00; 60p-£1.00; 10p-60p; 25p-50p.

The above 44 centres have, between them, 49 Condover people for whom I have worked out their position on their centre's scale, expressing the wage as a percentage on the scale. I have related this position to each individual's degree of vision and I summarize these figures in Table 5.IV.

Table 5.IV Amount of Pay as Percentage of Range. N=49.

	At Minimum	Below 20%	20-49%	50-79%	Above 80%	At Maximum
PS	1	0	9	2	0	0
PB	0	4	5	5	0	0
B	6	7	7	1	1	1
Total	7	11	21	8	1	1

There are so many variables and lack of really consistent information that the statistics of Table 5.IV are not suitable for detailed analysis. The only conclusion which it is reasonable to draw from the pay figures is the rather obvious statement that blind people perform much more poorly in work activities than the partially blind and the partially sighted.

The majority of the sighted mentally handicapped people for whom these centres were developed have intellectual handicaps corresponding to the categories (B) and (C) which I am using throughout the research. To show the intellectual handicaps of the Condover ex-pupils I have prepared Table 5.V, which retains the framework of the rates of pay from Table 5.IV, since it helps with the discussion which follows. There are 11 people who were not included in Table 5.IV because some attend A.T.C.'s with a flat rate of pay and I had incomplete figures about the others. To deal with the whole group of 60 in Table 5.V I have added a seventh column for these eleven others, putting figures in brackets to indicate that I have estimated each person's probable rate of pay. I have also redistributed these figures into the main body of the table.

Table 5.V Visual and Intellectual Handicaps with Reference to Rate of Pay. N=60.

Intellectual Handicap		Minimum	Under 20%	20-49%	50-79%	Over 80%	Maximum	Others
PS	Nil	0	0	0	0	0	0	(0)
	A	0	0	2	1	0	0	(1)
	B	1	0	7	2	0	0	(1)
	C	0	1	1	0	0	0	(2)
PB	Nil	0	0	0	0	0	0	(0)
	A	1	1	1	3	0	0	(1)
	B	0	3	5	1	0	0	(3)
	C	1	1	2	1	0	0	(2)
B	Nil	0	2	1	0	0	0	(0)
	A	3	2	5	0	1	1	(1)
	B	3	3	2	1	0	0	(0)
	C	1	0	0	0	0	0	(1)

Comments

(1) There are three blind people with no intellectual handicaps and 12 blind people with intellectual handicaps (A). These 15 blind people tend to be placed towards the lower levels of ability in work activities as measured by the pay scales.

(2) There are three partially sighted and six partially blind people of intellectual handicap (A), who are fairly well scattered among the pay scales.

(3) From the two columns, "Minimum" and "Under 20%" we see that only two out of 15 partially sighted people earn less than 20%. For the partially blind the numbers are seven out of 20 while for the blind the proportion is as many as 14 out of 25.

Evaluation of Suitability of Placements in A.T.C.'s

Procedure: I will use Table 5.V as a basis, admittedly somewhat arbitrarily chosen, on which to evaluate the placement of ex-pupils in A.T.C.'s. I am linking up here with the discussion of mental handicap which I introduced earlier and I shall start from two hypotheses:

(i) that visually handicapped people with intellectual handicaps (B) and (C) are mentally handicapped according to the definitions of subnormality in the Mental Health Act. The majority of sighted members of A.T.C.'s are of similar intellectual level. Therefore, even if an alternative placement were available in a centre specialising in the care of visually handicapped people, these ex-pupils with handicaps (B) and (C), 36 in number, need A.T.C. type of care;

(ii) that the 24 visually handicapped people with no intellectual handicap or with handicap (A) may be properly placed in an A.T.C. or may need placement elsewhere.

Since I feel that people in the blind category warrant special consideration, I shall consider the 60 ex-pupils in three groups according to the three grades of visual handicap. In each group I shall present:-

(a) tables of personal statistics of people with intellectual handicaps (B) and (C), giving a few selected case descriptions;

(b) case descriptions of all the people with no intellectual handicap or with handicap (A), aimed at making decisions about the suitability of placement.

To widen the discussion, I add two topics:-

Present Occupation Performance Compared with Original Occupation Estimate The occupation estimates used throughout the research were made by me at the beginning of the enquiry and were based on people's abilities at school leaving time. To compare this estimate with present performance I assessed each person's work in his centre, basing this assessment mainly, but not completely on the pay scales. It seemed reasonable also to assume that anyone below 20% on the scale was working at category (iv) level — "diversionary occupation only" — and that people in the range 20%-80% were at category (iii) level — "capable of some simple work-type occupation". Anyone earning above 80% might well be suitable for sheltered employment, category (ii).

Parents' Satisfaction with Placement The Parents' Questionnaire which I used had some questions which involved the choice of answer between "well satisfied", "fairly well satisfied" or "dissatisfied". One question concerned parents' feelings about the placements of their sons or daughters in work or occupation, but some parents thought that the activities of a centre were not classifiable as work or occupation and gave no answer. In most of these cases I have been able to supply an answer based on notes I took when I was interviewing parents.

(i) 15 Partially Sighted People

For convenience I reprint here the appropriate section of Table 5.V

Intellectual Handicap	Minimum	Under 20%	20-49%	50-79%	Over 80%	Maximum
Nil	0	0	0	0	0	0
A	0	0	2	1	0	0
B	1	1	7	2	0	0
C	0	0	1	0	0	0

In Table 5.VI I use the usual handicap scoring system, summarised on the marker.

The column "Actual" shows my assessments of present occupation performance. The column "Parents" indicates their feelings about the placement in a centre thus: (S) - well satisifed, (F) - fairly satisfied, (D) - dissatisfied, (O) - the person has no parents, (?) - no reliable information.

Table 5.VI Personal Statistics of 12 Partially Sighted People with Intellectual Handicaps (B) and (C).

	Int. H'cap	Age	Phys. H'cap	Beh. H'cap	Deafness	Epilepsy	Estimated	Actual	Parent
Miss K.D.	C	26	-	M	-	E	v	iv	S
Miss N.L.	C	36	-	-	-	-	v	iii	O
Mr. D.C.	B	28	-	m	D/B	-	iii	iv	F
Miss Q.B.	B	30	-	-	D/B	-	iii	iii	S
Mr L.A.	B	40	b	-	-	-	iii	iii	S
Mr. S.Q.	B	34	b	-	-	E	iv	iv	S
Mr. V.H.	B	22	-	m	-	-	ii	iii	?
Miss I.N.	B	27	-	-	-	-	iii	iii	F
Mr. V.I.	B	23	-	-	-	-	iii	iii	F
Miss T.H.	B	28	-	-	-	-	iv	iii	F
Mr. C.N.	B	28	-	m	d	-	ii	iii	F
Mr. V.T.	B	24	-	-	-	-	iii	iii	S

Comments

(1) All 12 people are acceptable to the staffs of the A.T.C.'s.

(2) Three people, whose present occupation performance is lower than their estimate, are mentioned either in Comment (3) or in the case descriptions. Three other people are functioning better than I had expected and the rest are at the level I estimated.

(3) Two people have a high occupation estimate (ii) but a performance of (iii):- Mr. C.N., whose Centre Manager assured me that C. has no realistic possibility of being employed in open or sheltered conditions, and Mr. V.H. who has shown behaviour difficulties and is likely to remove himself from his A.T.C. The "?" in the parent column is significant — V. gets little or no realistic guidance.

(4) I give three case descriptions:- Mr. V.T. because he might, just possibly, have employment possibilities, Miss N.L. because of her improved performance since she left school, and Mr. D.C. because his occupation performance is the lowest of the group.

Mr. V.T., aged 24, has no additional handicaps now. I find this strange but I am not prepared to question the opinions of his parents and his A.T.C. staff, especially in the light of his controlled behaviour when I saw him at his home and at his A.T.C. At school he had a severe behaviour handicap (M), which decreased to (m) by school leaving time. When he went home he found no occupation and was admitted as a patient to a psychiatric hospital though the circumstances are far from clear. His parents took him back home when they considered that their son was being ill-treated at the hospital which, incidentally, was later officially criticised severely for this type of treatment to patients. V.'s parents are well satisfied with his placement at his A.T.C. His occupation estimate was (iii) and he is working at the upper range of this category. If he should continue to improve, he might well manage a portering job similar to those being carried out by a few ex-Condover people already at work. This would be an example of a promotion from an A.T.C. of a mentally handicapped member, the visual handicap being of minor importance.

Miss N.L., aged 36, has no additional handicaps. She has no parents and is happily placed in a hostel and works well at her A.T.C. at level (iii). It is interesting to note that this woman was discharged from Condover in its early days as ineducable and had then an occupation estimate of (v).

Mr. D.C., aged 28, is deaf-blind and has a behaviour handicap (m). He has no effective method of communication. Although he is described as deaf-blind, he is really partially sighted. His parents are fairly satisfied with his placement at the A.T.C. His occupation estimate was grade (iii) but his level of work is at grade (iv) or nearly (v). The trouble is that, though his manual ability is fairly good and he masters some of the centre's work activities, he sees no point in repeating frequently a job which he has learned. He often resents staff efforts to get him to understand that work needs this repetitive operation.

Three Partially Sighted People with Handicap (A)

Three people have a moderate intellectual handicap and the appropriateness of their placement in an A.T.C. can be questioned. I examine their cases in some detail.

Miss I.N., now aged 37, is the one about whom I have the least information. Originally she was on my list of untraced people and I only found her towards the

end of my research period. Her parents had died and the only interested relatives felt they could not offer her accommodation so she was living in a hostel for mentally handicapped children. Three women from a local hospital also live in the hostel, have domestic duties and also attend the hospital's occupation centre. When I visited Miss I.N. she was unhappy about her situation since, although she helped with the domestic duties, she had long periods of inactivity. There was an irrational element about her conduct which made me score her as having a behaviour handicap (m). Recently I have heard that she is attending an A.T.C. but I have not been able to visit her and have received no replies to two postal enquiries. On my occupation estimate scale I rank her as (ii) and I hope that the placement in the A.T.C. will help solve some of her problems and that it could lead eventually to simple employment.

The other two people of intellectual handicap (A) are men and the parents of both are dissatisfied with their son's placement in A.T.C.'s.

Mr. Q.D., now aged 34, is quite severely spastic and has asthma. His sight is effective enough for him to use his electrically propelled vehicle, which is capable of slow speeds only, in the quiet roads around his home. Inside the house he uses a walking frame. Mr. Q.D.'s asthma restricts his activities, and he quickly tires. Although his widowed mother is dissatisfied with her son's placement in the A.T.C., he himself is very well satisfied. He feels that he is really doing some work there and is not distressed by the 'mental handicaps' of other members. An actual quote from Q. is "Oh, the mental handicap — that's immaterial" and he referred to the mentally handicapped as "human beings who need help". I saw Mr. Q.D. at his centre where he certainly seemed happy and was working at a level equivalent to his occupation estimate of (iii). I am sure that mother's dissatisfaction is due to the uncertainties of the future when, because of age or death, she would no longer be able to provide for her son the very pleasant life situation which exists now.

Mr. U.Y., now aged 24, had a heart condition which restricted his activities when he was a boy but an operation while he was at school improved matters and he is now able to live normally. Although I have rated U. as having an intellectual handicap (A) this was very much a border-line decision and he could easily have been rated as having no intellectual handicap. He is tall — well over six feet — studious looking, very polite, diffident and, I suspect, very worried by the fact that he is not working. Mr. U.Y. was one of the first people I visited in my research survey and at that time he was attending the annexe of an A.T.C. where people with special problems were placed. He was using a simple jig to fold paper hats. He seemed embarrassed to show me this very simple operation and actually said "Do you think I will be able to get a job?" Later, when I saw him at his home he embarrassed me by asking "Can <u>you</u> help me find a better job?" There have been improvements in U.'s situation since that time since he has been transferred to the main A.T.C. where there are more activities. His pay is now at the average rate instead of at one small stage above the minimum and he is working at the level of an occupation estimate of (iii). I had estimated an occupation level of (ii), but perhaps this was too optimistic. The fundamental problem remains: he is essentially an unpractical person and he has no abilities which would make it possible for him to perform non-manual work. I quote a general note which the manager wrote on his questionnaire: "There appears to be a lack of after-care for the blind in this area. Maybe I do not make enough enquiries myself, or there is apathy of Social Workers, etc." I think that the staff of the A.T.C. overestimate the severity of Mr. U.Y.'s visual handicap — he reads large-type library books. U.'s parents are dissatisfied with his placement in the A.T.C. and so, by implication, is the young man himself. My initial solution for the problem is that Mr. U.Y. should have a course in a rehabilitation centre for the

visually handicapped. One of the two occupations reserved for handicapped people under the Disabled Persons (Designated Employments) Order 1946 is that of passenger lift attendant and I can imagine U. being successful at this job.

(ii) 20 Partially Blind People

For convenience I reprint the appropriate section of Table 5.V.

Intellectual Handicap	Minimum	Under 20%	20-49%	50-79%	Over 80%	Maximum
Nil	0	0	0	0	0	0
A	1	1	1	3	0	0
B	0	3	5	1	0	0
C	1	1	2	1	0	0

Table 5.VII 14 Partially Blind People with Intellectual Handicaps (B) or (C).

	Int. H'cap	Age	Phys. H'cap	Beh. H'cap	Deafness	Epilepsy	Estimated	Actual	Parent
Mr. E.H.	C	30	b	-	-	E	v	iv	S
Mr. K.I.	C	30	b	-	-	E	iv	iv	F
Miss C.D.	C	23	-	m	-	-	iii	iii	F
Miss N.C.	C	20	a	m	-	-	iv	iii	S
Mr. K.C.	C	30	-	-	-	E	iv	iii	F
Mr. L.H.	B	31	a	m	-	-	iv	iv	F
Mr. S.Q.	B	31	b	-	-	-	iv	iv	F
Miss D.T.	B	26	b	-	-	-	iv	iv	F
Mr. N.H.	B	23	-	m	d	-	iii	iii	S
Mr. Q.A.	B	22	c	-	-	-	iv	iv	S
Miss M.G.	B	23	-	-	-	-	iii	iii	F
Mr. B.X.	B	32	-	-	-	-	iv	iv	F
Mr. Q.K.	B	28	-	-	-	-	iv	iii	S
Mr. N.K.	B	28	-	M	-	-	iv	iii	F

Comments

(1) All 14 people were acceptable to the staffs of the A.T.C.'s.

(2) Five people are functioning now somewhat better than I had expected and the others at the level I estimated.

(3) I give two case descriptions as examples of the way in which A.T.C.'s accept people with multiple handicaps.

Mr. E.H., aged 30, has physical handicaps of category (b) and has frequent petit mal attacks. His parents withdrew their son from Condover after six months as they considered that the terrain there was too difficult. His parents are well satisfied with their son's placement now. His father is a crusader on behalf of the mentally handicapped in his remote rural county. His efforts, which are thoroughly approved by the staff of the A.T.C., include accumulating money to build a hostel for members of the A.T.C. The young man was possibly graded too low for occupational estimate in category (v) and he functions now at level (iv).

Mr. N.K., aged 24, has a severe behaviour problem (M). After four years at Condover he was discharged as ineducable at the age of 14. His behaviour problem took the form of obsessional conversation and a lack of appreciation of reality. He is still a very withdrawn person, and, though he shows some improvement, I still rank his behaviour problem as (M). Although N.'s parents are only fairly

satisfied with his placement, he is acceptable to the staff of his A.T.C., who are sympathetic to his difficulties and have allowed him to develop his skills in simple craft work in a centre which is rapidly turning to contract work of a repetitive nature. His occupation estimate was (iv) but he is working at (iii).

Six Partially Blind People with Handicap (A)

Column 1

Mr. E.S., aged 23, has physical handicaps of category (b). If he had not been fairly mobile, I would have considered him as of category (c), because his muscular co-ordination is so poor that his manual ability is very low indeed. I placed him in category (iv) for occupation estimate but only just outside category (v). He is working at this level in his A.T.C. E. has a quite severe speech impediment. With all his difficulties, however, he is a very pleasant young man and his intellectual handicap is definitely no worse than (A). I have seen E. at his centre where it is evident that he receives sympathetic and encouraging support from the staff. They recognise his comparatively high intelligence compared with most members of the centre and have devised educational programmes for him. I certainly consider that this is a good placement for Mr. E.S. His unusual needs are recognised and individual treatment is given.

Column 2

Mr. Q.T., aged 22, presents very serious problems with some distressing aspects. He has physical handicaps of category (b), suffering from a spastic hemiplegia severe enough to render one arm practically useless. The leg on the same side is also affected so that, not only does he have a pronounced limp but he also has a lurching, uncertain gait. Q. has a severe behaviour handicap of category (M) and he has had aggressive episodes directed against his mother which caused her real fright. All his handicaps, including his poor vision and some minor epilepsy, are a consequence of encephalitis following measles which he contracted at the age of nine. Since he left school Q.'s parents have tried to find a placement for him, preferably residential. He had an assessment period of 13 weeks at a hospital for the mentally subnormal but the staff decided he was unsuitable for admission there since he was not mentally deficient having obtained an I.Q. measurement of 82. Next he was tried at an epileptic colony which provided pleasant residential conditions, but Q. was left alone for long periods during the day while other patients attended the colony's occupation centre. This exclusion, his parents think, was because of their son's visual handicap and they decided to withdraw him. Sometime during this period Q.'s father became seriously ill and accepted an invalid's pension from the ambulance service which employed him. Mother started to go to work. Q. was next admitted to the Wilberforce Home for Multi-handicapped Blind Adults where all was well for a few months until Q.'s aggressive behaviour led to his discharge. Father decided to give up his invalid pension, register as unemployed and seek some form of re-training. Q. is now attending an A.T.C. where, so far, i.e. for about a year, he has posed no serious problems though he is frequently difficult at home. He travels to and from home with the Social Service Department transport which tends to be erratic as far as timetable is concerned because of the many calls for the use of the coach. Q. cannot be left at home alone — his parents state — and mother still goes to work so father has been unable to take the course of training for which he hoped. When I last heard from the family, father was hoping that he might develop, as a self-employed person, some kind of business which he could run from home. I realise that I have presented this severe problem from the point of view of the parents who feel incensed at what they consider to be the Local Authority's inability to help. I know, however, that the appropriate Social Services staff are fundamentally

sympathetic and the Authority would pay the fees for residential placement for Mr. Q.T. if it could be found. In fact the Authority supported the three trial placements which I mentioned earlier. Nothing has been found but, meanwhile, an A.T.C. is giving considerable help and relief in this very complex, difficult situation. Q.'s occupation estimate was (iv) but at the centre he works at level (iii).

Column 3

Miss D.I., aged 28, has physical handicaps of category (a). One hand is fairly useless though she can use it as a support for activities carried out mainly by her other fairly capable hand. She still has the pleasant, helpful, rather shy personality which she had at school. D.'s parents say they are fairly well satisfied with her placement at the A.T.C. I have seen an 'Other Day Centre' for the Physically Handicapped in the same area but I do not know if transport would be available to take D. to it. In any case, I am quite sure that she is better placed where she is, at least until there is improvement in the facilities and services of the Other Day Centre.

Column 4

Mr. L.Q., aged 31, is a very unusual person who has found a very pleasant way of life, in which his A.T.C. plays an important part. Although he has no marked additional handicaps, his hands are only fairly effective, being rather clumsy. He has a minor speech handicap which, combined with his very rapid method of talking, makes him difficult to understand at times. When I visited his centre he was deputed to act as my guide, a job which he carried out very well. En route I met his instructor who told me that L. is worth the money he is paid for his work. The instructor pulled L.'s leg about the County Cricket Club whose headquarters are in the same town as the A.T.C. L. is a member of the County Club and often goes to matches, where he sells programmes. He takes three months holiday from the centre during the winter to sell County Cricket Club draw tickets, having established a sales territory mainly in shops and offices in several towns in the area. I took L. to his home where he lives with his widowed mother. When I came away, I was asked to drop him at the local railway station where he was catching a train to London, 50 miles away, where he was due to meet a friend at Victoria Station and they were going to a concert at the Queen Elizabeth Hall. A portly little man, eccentric, with abrupt flamboyant gestures, armed with his short white stick and abundant self-confidence, he is prepared to go almost anywhere. Nevertheless, I cannot imagine him working in open or sheltered employment since he is illiterate and not capable of manual work any more skilled than that he performs at the A.T.C. If an Other Day Centre were available it might be more suitable for Mr. L.Q.

Miss K.L. is aged 22 and is just about as dissatisfied with life as Mr. L.Q. is satisfied. She has a behaviour handicap which I have rated as (m). She has some excuse for feeling frustrated but she has never been able to view her employment prospects realistically. Until age 16 she attended a school for the partially sighted and then applied to attend one of the vocational assessment centres for the blind. The head of this centre asked us to take her at Condover for a period of social education, after which she was admitted to the vocational assessment centre where she and her mother consider that she "passed". K. had always wanted to work with children and she went daily for three months to a special unit for seriously emotionally disturbed children in a local hospital for the mentally subnormal. At the end of this period, when she thought she would be employed at the hospital, she found that she was going to be a voluntary worker receiving free meals only — and her daily fares were 35p! The local Disablement Resettlement Officer and one of the R.N.I.B.'s Placement Officers tried to find

her employment. Once a job seemed imminent but this faded out, because it appears, K.'s mother turned down the suggestion that her daughter should do canteen work — at which she might have done quite well. So, for something to do, K. attended the A.T.C. where the manager says that she acts as if she were well aware of her superiority to the other members of the centre. This is a difficult situation but the A.T.C. is acting as a base from which, with luck, she will find work. No other Day Centre is available nor is a sheltered workshop.

Mr. N.O., aged 30, attends the same A.T.C. as Miss K.L. Although the manager says that N. is not a behaviour problem, there are some disturbing factors. N. is often worried — about health, the death of his mother, etc. Sometimes he works too hard, feverishly at times, and he needs constant reassuring and attempts to make him relax. Since my visit to see N. I know he has been receiving psychiatric treatment for obsessive worrying and I think he should be considered as having a behaviour handicap, category (M). One worry which he expressed to me concerned his "brain". "I'm not all that mental am I?" If it were not for these behaviour anomalies I would have thought that he was well placed in his A.T.C. There is no alternative placement available. If a sheltered workshop for the Blind had been available in their town, admission there could well have been a solution of the difficulties of Miss K.L. and Mr. N.O.

(iii) 25 Blind People

For convenience I reprint here the appropriate section of Table 5.V.

Intellectual Handicap	Minimum	Under 20%	20-49%	50-79%	Over 80%	Maximum
Nil	0	2	1	0	0	0
A	3	2	5	0	1	0
B	3	3	2	1	0	1
C	1	0	0	0	0	0

In this third section of the evaluation of placements in A.T.C.'s I will reverse the procedure which I have adopted in the two previous sections and will begin with the case descriptions of the more intelligent people in the blind group.

As an introduction I put forward, rather tentatively, the concept of "being good — or being poor — at being blind". Most blind children who have no marked additional handicaps adjust to the problems of their blindness by making use of other senses, particularly hearing and touch. They learn to read and write braille, develop good manual abilities, and learn how to orient themselves in space, moving with confidence in known environments. There are, of course, considerable individual differences in the development of this sensory compensation, but there are a few blind children whose progress is so minimal that it seems almost pathological. They remain surprisingly inept and unpractical, and do not learn to be "good at being blind". The cause is not known but it seems likely to be neurological or cerebral in origin. This lack of specialised development is at its most puzzling when it occurs in people of normal intelligence and, to a lesser extent, in people with only a moderate intellectual handicap. There are a number of people with this type of difficulty among the people I shall discuss in this section and I will begin by describing a young man who is very "poor at being blind" and who is an outstanding example of this strange handicap.

Three Blind People with No Intellectual Handicap

Mr. H.S., now aged 23, has what I feel tempted to describe as a syndrome, though there are no medical causes to report, only a collection of symptoms which I will enumerate: total blindness, normal intelligence, good verbal facility, poor manual skills, very poor orientation for mobility and for hand/touch exploration. It is as though the information fed in by the senses does not get properly organised. At school he had wide conversational interests — and still has — in sport, politics, news, serious radio programmes, etc., but he made almost no progress in the learning of braille. As a boy and now as a man, he has experienced difficulty with most practical activities and this is a crucial matter when any occupation or work is being considered. When he left school, vocational assessment was impossible and he stayed at home for two years with nothing to do in terms of occupation, since there was no centre of any kind in easy reach of his home.

In the course of my research I first met H. at a Home for Spastics where he was resident during the week, going home for weekends. The Home was intended for the use of physically handicapped adults of 18-35 years of age, but now has only 12 adults and takes 28 spastic children, mostly severely intellectually handicapped with other handicaps, too. Apart from radio listening and conversation, H. was largely unoccupied. The Matron was troubled by this and tried to help him to improve his standards of self-care in which she was hampered by lack of staff and the young man's own temperament, in that he seems quite content to do nothing of a practical nature.

At last he has been found a place in an A.T.C. The manager and his staff consider that their centre is unsuitable for H. on two counts: his blindness and his normal intelligence. They tend to ascribe his failure in the work occupations of the centre to their own lack of ability to deal with his blindness. The manager, in conversation with me, when I commented that my occupational estimate for Mr. H.S. was of category (iv), made the valid point that if H. is only capable of diversionary occupations he should carry these out in a centre where the members are more responsive and intelligent, where some educational facilities are available and, very importantly, where there is residential accommodation. No such facility is available so I hope he will continue to attend the A.T.C. for the time being. When I made a special visit to his A.T.C. I found that H. is placed in the centre's section for the most seriously handicapped, but the staff make some use of his ability in story-telling and his pleasant singing voice in entertaining the members of this special section. At least he is under the umbrella of the Social Services Department and the centre staff are likely to agitate for his better placement. As one would expect, his parents are dissatisfied with their son's present placement though they are well satisfied with the financial arrangements. Meanwhile, H., at any rate, remains his pleasant untroubled self which is, I suppose, fortunate.

Mr. J.N., now aged 24, had a very severe behaviour handicap as a young child. Although this gradually diminished as he grew older, a situation which he regarded as a crisis could cause a relapse in behaviour and this was still evident at school leaving age when I thought he still had a behaviour handicap of category (m). The behaviour difficulties had caused considerable retardation of his educational progress but he gradually acquired enough skill in braille to allow him to read braille magazines, though he is not a member of the Braille Library. A considerable element of timidity was a feature of his behaviour and this retarded his development in manual skills so that, at school leaving age, he could only be given a ranking of (iii) in the occupation estimate scale. As expected, there were difficulties about placement. First he attended daily at the Occupational Therapy Unit of a Psychiatric Hospital where the other members of the

unit were recovering from mental illness. J. was sent here, not for medical reasons, but because the atmosphere and work seemed more suitable than those at an A.T.C. I visited him at the Unit where he had the companionship of another young blind man whom he had known when both were pupils at Condover. Unfortunately the Unit later had to confine its activities to hospital patients and J. had to spend 14 months at home without occupation. During this period there were periods when a behaviour relapse seemed iminent. Now he attends an A.T.C. and it is to be hoped that a return to a more settled state of mind may be possible. J.'s parents are dissatisfied with the placement but alternative placements are non-existent. I feel he would be better placed in an Other Day Centre.

Mr. E.Q., now aged 22, is in the upper range of normal intelligence. He has a physical handicap of category (b). Employment for totally blind, physically handicapped people presents great difficulties. After having spent four years without occupation, though he had leisure time interests so that he was not completely inactive, he reluctantly decided to accept placement at an A.T.C. hoping this might be some sort of starting point. There is one hopeful fact that, in his city, there is a sheltered workshop for the blind which is beginning to admit handicapped people of other types. It is to be hoped that some sort of employment for E. will be found at the workshop even if it is of an unconventional nature. His parents are dissatisfied with the A.T.C. placement, and if there are no developments soon for their son, no doubt he too will be dissatisfied. I think E. has more employment potential than his occupation estimate (iii) indicates, but he could only realise it in some non-manual work because of his physical handicap. Mr. E.Q. urgently needs reassessment based on the local Sheltered Workshop.

12 Blind People with Intellectual Handicap (A)

Column 1

Miss E.H., aged 26, has no additional handicap but she suffers from what I have described as an abnormally poor sensory compensation for blindness. Her parents are fairly satisfied with their daughter's placement. E., herself, seems quite happy at the centre and shows a pleasant trait that was also useful at school — an ability to talk sensibly and encouragingly to people showing disturbed behaviour. As I feel that the occupation estimate of (iv) was correct it is not surprising that she failed a trial period in a sheltered workshop. Her work in the centre is of (iv) level.

Mr. T.I., aged 23, has physical handicaps (b) and behaviour handicaps (m). His parents are fairly satisfied with his placement in the A.T.C. and T. seems reasonably happy there. He attends the same A.T.C. as Miss E.H. and sometimes profits from her soothing conversation. Mr. T.I.'s multiple handicaps are equivalent to a mental handicap.

Mr. N.I., aged 27, has no additional handicaps, though he has developed diabetes since he left school. He is another person with the abnormally poor sensory compensation for blindness. His parents are well satisfied with his placement. N. quite enjoys attending the centre where his intelligence and verbal facility are useful in educational classes and in occasional simple drama productions.

All these three people in column one were rated (iv) for occupational estimates, and work at this level now. In spite of their comparatively minor intellectual handicaps, they seem suitably placed in their A.T.C.'s. Transfer to an Other Day Centre, if it were available, would be a border line decision in in each case.

Column 2

Mr. S.F., aged 28, has severe behaviour handicaps (M). He is frequently irrational in conversation and behaviour, rarely revealing his intelligence. His parents are fairly well satisfied with his placement at the A.T.C. and its associated hostel. S. has perfect musical pitch and some facility in piano playing. At one time it was hoped that he might even train as a piano-tuner, but his handicaps were far too severe for this. His occupational estimate was then put as (v) and now he rarely does any work that can be described as better than this. He is fortunate to be placed in the A.T.C. and its hostel: if he had to stay permanently unoccupied at home, the considerable emotional strain caused there would be almost unbearable. The only alternative placement would be in a hospital for the mentally ill. Even if an Other Day Centre were available, I am sure his behaviour problems would make him unacceptable there.

Mr. G.K., aged 25, has physical handicaps (b). His parents are fairly satisfied with his placement. G. seems quite happy at the centre where the staff have devised jigs to help him perform simple jobs and his accuracy in counting numbers is useful in some packing jobs. His occupation estimate was (iv) but he works at times at level (iii). If an Other Day Centre were available, G. would probably be better placed there. I was a little disturbed that, sometimes, he seems to imitate the behaviour of the more intellectually handicapped members of the centre.

Column 3

Mr. H.T., aged 26, is deaf-blind and has physical handicaps (a). His deafness is quite severe but not total. Simple communication through speech is possible but rather difficult, but H. is a very pleasant co-operative young man. His parents are well satisfied with their son's placement and H. enjoys his life at the centre. H.'s temperament is such that he finds life almost anywhere enjoyable.

Mr. T.T., aged 24, has a physical handicap (a), a hearing loss of category (d) and abnormally poor sensory compensation for his blindness. He came to the A.T.C. after several years spent at home doing nothing and I think that, for T. and his parents, there are obvious advantages for him to continue to attend the centre at present. Nevertheless, his parents are dissatisfied with their son's placement in his A.T.C., and this was particularly so when he was placed in a special unit for difficult or unusual people. T.'s occupation estimate was (iii) and he barely reaches this level at the centre. He seems unhappy at the A.T.C. and another placement seems advisable. He would almost certainly be unsuitable for open or sheltered employment so an Other Day Centre, seems to be the solution.

Mr. S.B., aged 30, has a moderate behaviour handicap (m), more noticeable at home than at his centre, and also a minor hearing loss (d). His parents are well satisfied with his placement. S.'s occupation estimate was (ii) and, after leaving school he had a course of vocational assessment but was never found a job. At the centre he works effectively at level (iii). It would be worth while seeking assessment at the workshop for the blind which is only a few miles from his home.

Miss N.U., aged 28, has no additional handicaps apart from abnormally poor sensory compensation for her blindness. Although I have received no replies from N.'s parents in response to letters, I know from a personal interview that they are well satisfied with her placement at her A.T.C. Her occupational estimate was (iv) and she only just attains this level at the centre. The staff there feel that they are not doing enough for Miss N.U. and ask for specialist advice about how to

deal with her blindness. This advice has not yet been provided, but it is important that it should be given.

Mr. L.T., aged 29, has no additional handicaps apart from an abnormally poor sensory compensation for blindness. His parents (mother and stepfather) provide L. with a pleasant life. L. attends the A.T.C. where a recent change of manager has resulted in a considerable increase of purposeful activities for its members especially for L. He attends a weekly social for blind people where he enjoys playing dominoes and where he is an asset because of his very good piano-playing abilities. Mr. L.T. has undoubted musical abilities, being a very versatile and effective pianist, very quick to learn new pieces and accompaniments by ear. It is a great pity that this positive quality has not been utilised more. He has perfect musical pitch and had a trial training as a piano tuner at which he failed because of poor manual dexterity and orientation around the frame of the piano but his orientation on the key-board, when he is playing, is surprisingly good. This feature has been noted in about six other piano-playing Condover pupils with otherwise poor orientation. There are some hopeful signs about Mr. L.T.'s future: the manager of his A.T.C. is alert to L.'s positive abilities, and has interested his parents in the Centre's Parents' Association so that joint action should be possible. It could seem that Blind Welfare has failed in L.'s case but this is not completely true since L. has been taught to read and enjoy the Moon system of print for the blind. What has been lacking is a co-ordination of services on Mr. L.T.'s behalf, but there are hopeful signs that this will soon be available.

Columns 5 and 6

Here are found the only two people who are paid at or near the maximum rate of pay.

Mr. C.C., aged 23, has no additional handicaps. His parents are fairly satisfied with their son's placement. My visit to C.'s A.T.C. proved most stimulating because the staff are enjoying the challenge of having a blind person among the sighted members and he is encouraged to take a full part in all the centre's activities, including fairly adventurous weekend rambles and a chalet-type semi-camping holiday in Norway. His occupation estimate was (iii) and he seems to be operating at this level, perhaps a little higher in its range than I would have expected. There seems a strong case for Mr. C.C. to be considered for admission to a sheltered workshop for the blind but there are two problems. Can he achieve the standards required for admission requiring long periods of continuous work? Can he achieve enough independent mobility to travel to a workshop for which no special transport is provided, as there is for travel to the A.T.C.? A course of mobility training seems very necessary, whether as a help for promotion or simply as an improvement for C.'s present way of life. At school, he lived in a hostel and travelled independently to school, a journey involving two crossings of roads. Admittedly this was in a village, and though there was a fairly large flow of traffic, this was much less than in a city. On the other hand, there are no traffic lights and no pedestrian crossings at Condover. Nowadays he never walks alone outside home.

Miss D.F., aged 23, has behaviour handicaps of category (m) though these appear to be decreasing. Living arrangements have always been unusual for D. Her widowed mother who remains responsible for D., has residential occupation where she cannot take her daughter who has been cared for by a lady, whom she calls Auntie, since infancy. Mother and Auntie are well satisfied with D.'s placement, though I think they would agree that her social life is too restricted. Her occupation estimate was (iii) and I was surprised and pleased to find that, in a range of jobs presenting no special difficulties for a totally blind person, she

was the speediest worker in the centre. Here again is someone who could be considered for admission to a sheltered workshop for the blind. As far as output is concerned she is better than Mr. C.C. but her problem of mobility is just as acute as his. In fact it is exactly similar: they both lived in the school hostel which I mentioned above, and Miss D.F. like Mr. C.C., now never walks alone outside home.

10 Blind People with Intellectual Handicap (B) or (C)

From my discussion of the cases of blind people with either no intellectual handicaps or of intellectual handicap (A), it is evident that the more seriously intellectually handicapped blind people might well be as suitable for placements in A.T.C.'s as the partially blind and partially sighted who are seriously intellectually handicapped. I shall therefore deal with the blind also by presenting a table of personal statistics, but because of the subjects complete lack of sight, I will give at least a brief note of each individual.

Table 5.VIII Personal Statistics (N=10)

	Int. H'cap	Age	Phys. H'cap	Beh. H'cap	Deafness	Epilepsy	Estimated	Actual	Parent
Mr. K.D.	C	26	-	M	-	E	v	iv	F
Miss L.N.	B	21	-	-	-	-	iv	iii	F
Mr. L.T.	B	22	-	-	-	-	iv	iv	S
Mr. K.S.	B	29	-	m	-	-	iv	iv	F
Miss K.I.	B	23	-	-	-	-	iii	iii	F
Miss E.I.	B	20	-	-	-	-	iii	iii	S
Mr. H.N.	B	34	-	m/M	-	-	ii	iii	?
Miss N.T.	B	25	-	-	-	-	iii	iii	F
Miss D.H.	B	22	c	m	d	-	iv	iii	D
Mr. V.H.	B	23	-	m	-	-	iii	iii	S

Comments

(1) Five people have behaviour handicaps. Messrs K.D., K.S., and V.H. really need the care of their A.T.C.'s and their blindness is coped with effectively there. The cases of the two other people warrant special case descriptions: Mr. H.N. because of his high occupation estimate of (ii), and Miss D.H. because of the multiple nature of her handicaps and her parents' dissatisfaction.

(2) Miss E.I. and Mr. L.T. are happy at their centres and their parents are well satisfied with their placements. Misses K.I. and N.T. are equally happy at their centres and although their parents say that they are only fairly satisfied with the placements I am sure they have no real cause for complaint. I have one reservation in that the staffs of two centres tend to underestimate the potential of two of the young women because of their blindness.

(3) I give a case description of Miss L.N. because of one feature of special interest.

Mr. H.N., aged 34, has a behaviour handicap of (m), which at times is severe enough to rank as (M). At school he was quite good at practical activities and had an occupation rating of (ii) but he has never realised this potential. He had an uncertain family background and, at times, had to be taken into Care. After leaving school, H. attended a Workshop for the Blind where he lived in a hostel. He was not trained but worked at simple tasks. There was a possibility that he would be transferred to a Home for the Mentally Handicapped but, at age 20, he returned to his own home. He has been to centres of different types and now attend

a large A.T.C. with 160 members, where he has the opportunity of performing a wide range of tasks. Mr. H.N.'s instructor has been surprised by his occasional good performance in a few jobs, but H. is unco-operative, behaves in a childish fashion to attract attention and will retire for long periods to the toilet where he smokes and plays the mouth-organ. His lack of co-operation extended to training in mobility, where after having made a good start, he gave up trying. Unfortunately I have not been able to establish any contact with Mr. H.N.'s parents.

Miss D.H., aged 22, presents problems because of the complexity of her handicaps. She is severely physically handicapped, is slightly deaf, has a fairly severe speech difficulty and, not surprisingly, has behaviour handicaps which I rate as (m). Her parents are worried about the 'mental' handicaps of the other members of the A.T.C., yet, when I saw D. at this centre, I was surprised by the quality of her work which seemed somewhat higher than the occupational estimate of (iv) which I had given her. She gets considerable individual attention from the staff who think, however, that Miss D.H.'s blindness and physical handicaps need more specialised treatment than they can give. Fortunately her Local Authority has an Other Day Centre for the physically handicapped where she attends one day per week and eventually she might attend this permanently. D.'s parents are dissatisfied with the poor quality of her social life outside the family, though there has been a recent hopeful development in that D. has just joined the local P.H.A.B. club. I very much respect D.'s parents and their desire to do all they can for their daughter, but I doubt if they realise the limiting effects of her serious handicaps. However, I have some disquieting thoughts about D. myself: she seems more sensible and intelligent than I was expecting and I think that we should probably have kept her at school for a year or two beyond school leaving age. In view of the possibility of an alternative placement for Miss D.H., I make no statement about her attendance at the A.T.C., though, if this had been the only possibility for her, I would have considered it satisfactory.

Miss L.N., aged 21, could almost have been classified as (A) for intellectual handicaps and she has no marked additional handicaps. She came to Condover at age 16 for a year's social education. Previously she had learned to read braille, but had not acquired many practical skills. Her widowed mother is only fairly satisfied with L.'s placement at the Centre, but I think she should not worry about this. There are two other visually handicapped people at the centre where they form a sub-group receiving special attention because of their visual handicap.

Summary of Evaluation of Placements

A resumé of all the above evaluations is given in the Summary and Recommendations section at the end of the chapter.

SECTION (B):- 27 CONDOVER EX-PUPILS IN OTHER DAY CENTRES

My enquiry into the placement of Condover ex-pupils in day centres other than A.T.C.'s for the Mentally Handicapped supports the statement by the Working Party on the Training Needs of Staff in Day Centres, to which I referred in the opening section of this chapter, that the development of these other day centre services has been slow and uneven. I have found the situation very confusing and I am afraid my bewilderment is likely to be very evident as I attempt to provide a coherent account of the 27 ex-pupils who attend these Other Day Centres.

I come immediately to a complication. I have included in Section (B) two sub-groups, each of three men who could well be classed as mentally handicapped and whose centres have considerable similarities to A.T.C.'s but I have taken this action because I wished to reserve Section (A) for a homogeneous group of definite A.T.C.'s. One sub-group consists of men who attend different Hospital Occupation Therapy Units or Industrial Training Units as day patients. The second sub-group attend the only specialised day centre for multi-handicapped blind people. I will give special consideration to these six men later.

This leaves 21 ex-pupils who attend Day Centres for the Physically Handicapped, with or without specialist services for the blind. There is a considerable variety of these Other Day Centres, but all would, presumably, officially exclude the mentally handicapped. Some are organised by the Spastics Society, others are recently developed Local Authority Centres for the Physically Handicapped; some have been developed from former Social and Handicraft Classes for the blind. Some centres are work-orientated and deal mainly with people of "working age"; others deal with a wide range of handicapped people, including the elderly, many of whom attend only occasionally, but some centres provide a five-day week service for some younger people also. I have divided the Other Day Centres, with which I deal in this chapter, into two groups:-

(a) There are eight centres for the physically handicapped admitting between them ten Condover ex-pupils. Most of these centres are described as "Work Centres", but they should not be confused with Sheltered Workshops, where workers are fully employed and receive wages. Members of Work Centres receive Social Security payments and are subject to the usual upper limit of payment for work of £2.00 per week.

(b) There are ten other centres, admitting between them 11 Condover ex-pupils, which, in various ways, have definite responsibilities for blind people but some also care for other types of handicapped people. I will refer to these centres as "Blind Plus" Centres.

General Statistics Concerning Centres

(1) Numbers of members. Physically Handicapped: total 457, including 15 visually handicapped extra to the ten 'Condovers'.
"Blind Plus": numbers not really relevant because of large number of part-time attendances. Approximately 250 blind people of all ages attend.

(2) Transport: all centres provide free transport.

(3) Mid-day meals. Physically Handicapped: all centres provide meals, two free, others charge from 35p to £1.00 per week.
"Blind Plus": two no information, one no provision; six make charges from 35p to £1.00; no free meals.

(4) Pay Schemes. Physically Handicapped: all except one operate schemes. Four have flat rates (£1.00, £1.25, £1.50, and £2.00). Scales in the other

three are: 15p to £1.00, 75p to £1.75, and 50p to £2.15. "Blind Plus": four do not operate scheme; two make occasional small payments based on profit made by sale of individual's production; two pay a flat rate of £2.00; one has a scale of £1.25 to £2.05; one operates a scheme but gave no details.

(5) Education Schemes. Physically handicapped: only two centres provide. "Blind Plus": two no information; six provide; two do not.

(6) Clubs. Physically Handicapped: five provide; three do not. "Blind Plus": five provide; four do not; one no information.

(7) Holidays. Physically Handicapped: all organise outings; four provide summer holidays of one week. "Blind Plus": seven organise outings, four of these providing summer holidays of one week also; three make no provision.

Note. Three Local Spastics Societies are very active in support of their special centres. One Local Authority centre for the physically handicapped has a very active Friends' Committee. Otherwise there are no Parents, Friends, organisations.

Handicaps of Ex-pupils Attending Other Day Centres

I include in Table 5.IX statistics for the two sub-groups as well as the main groups.

Table 5.IX Handicaps of Ex-pupils attending Other Day Centres (N=27).

		Physically Handicapped Centres(10)	Blind Plus Centres (11)	Total Phys. Handicapped & Blind Plus	Multi-H'capped (3)	Psych. (3)	Totals (27)
Sex	M	4	9	13	3	3	19
	F	6	2	8	0	0	8
Vision	PS	1	2	3	0	1	4
	PB	4	2	6	2	0	8
	B	5	7	12	1	2	15
Intellectual Handicap	Nil	4	2	6	0	0	6
	A	3	8	11	1	3	15
	B	3	1	4	1	0	5
	C	0	0	0	1	0	1
Physical Handicap	Nil	4	8	12	0	3	15
	a	1	1	2	2	0	4
	b	3	1	4	0	0	4
	c	2	1	3	1	0	4
Behaviour Handicap	Nil	8	10	18	2	0	20
	m	2	1	3	0	3	6
	M	0	0	0	1	0	1
Deafness	Nil	10	10	20	3	2	25
	d	0	1	1	0	1	2
	D/B	0	0	0	0	0	0
Epilepsy	-	1	3	4	3	0	7
Promoted	-	0	1	1	0	0	1
Discharged	-	1	0	1	0	0	1
Work Estimate	i	0	0	0	0	0	0
	ii	1	7	8	0	2	10
	iii	5	4	9	0	1	10
	iv	2	0	2	3	0	5
	v	2	0	2	0	0	2

Comments (excluding the two special sub-groups)

(1) The high proportion with Nil and (A) intellectual handicaps was to be expected. Bearing in mind my discussion of A.T.C.'s and mental handicaps it could be surprising to find four people here with handicap (B). I will pay special attention to these people when I examine individual cases in more detail.

(2) I was surprised to find as a large number of people as eight who were classified as (ii) for occupational estimate. I will discuss this matter later too.

Table 5.X Personal Statistics of Ten People Attending Centres for Physically Handicapped.

	Age	Vision	Int. H'cap	Phys. H'cap	Beh. H'cap	Deafness	Epi-lepsy	Esti-mated	Actual	Parent
Miss Q.T.	25	PS	A	a	-	-	-	iii	iii	S
Miss K.C.	22	PB	B	b	-	-	E	iv	iii	F
Miss N.M.	35	PB	Nil	c	-	-	-	iv	iii	F
Miss T.C.	21	PB	Nil	a	-	-	-	iii	iii	S
Mr. C.N.	31	PB	B	c	m	-	-	v	v	?
Mr. L.G.	23	B	Nil	-	m	-	-	v	iii	S
Mr. K.G.	21	B	B	-	-	-	-	iii	iii	S
Mr. C.H.	38	B	A	-	-	-	-	ii	iii	F
Mr. S.S.	25	B	A	-	-	-	-	iii	iv	?
Miss L.T.	21	B	Nil	b	-	-	-	iii	iii	D

Comments

(1) The range of work activities are very similar to those in A.T.C.'s.

(2) I have visited all the centres except Miss N.M.'s. The staff seem happy to take visually handicapped people.

(3) Even if alternative placements for Misses Q.T., K.C., N.M., T.C., and K.G. and Mr. L.G. were available I consider their present position is best for them.

(4) I draw attention to Mr. L.G. of whom I gave a long description towards the end of Chapter 3. This young man has been "promoted" from hospital and is now very well placed at his centre and its associated hostel. He has no parents and the indication of being well satisfied with his placement, given under the parent column, was furnished by me in loco parentis, as it were.

(5) I will give notes concerning three people with intellectual handicap (B), the man with occupation estimate (ii), and the woman whose parents express dissatisfaction.

Mr. C.N. It will be seen that this man is severely multi-handicapped and his intellectual and behaviour handicaps indicate that he needs classification as mentally handicapped. I am sure that he would be better placed in an A.T.C. At the time of my visit to C.'s home, his parents were obviously worried by his uncooperative, irrational behaviour. Since both parents are visually handicapped and are not in good health their son might well soon need hospital placement.

Miss K.C. and Miss K.G. both have an intellectual handicap (B) but their social behaviour is very acceptable. They are well-liked in their respective centres and the consideration of mental handicap need not arise. I am surprised that Miss K.C.'s parents are only fairly satisfied with their daughter's placement. She is happy and well occupied at her centre.

Mr. C.H. had an occupation estimate of (ii) when he left school but he did not go for trial training in a traditional craft, which was the only training available at that time. At his present centre he carries out simple assembly work very effectively. In the neighbourhood there is a Sheltered Workshop which has assembly jobs among its activities and it seems urgent that Mr. C.H. should have a trial there. There is an additional factor of importance:- C. lives with his elderly widowed father and the problem of residence is becoming urgent and the Workshop has recently opened a hostel which could solve the residence problem. Mr. C.H.'s situation is well known to officials, but no positive action about admission to Workshop and Hostel has been taken. From time to time the suggestion has been put forward that there is a need generally for Local Authority Handicapped Persons Officers who would review situations and act on behalf of handicapped people. Here, with Mr. C.H., is an example where such an Officer could function.

Miss L.T. is the only blind, severely physically handicapped person, with no intellectual handicaps in the complete group of 27 people in the Other Day Centres section. People so seriously handicapped, but with normal intelligence, are more aware of their ineffectiveness as far as employment is concerned than less intelligent people. The problem can only be resolved by individuals accepting that employment is impossible, especially when, as in L.'s case, there is an element of abnormal lack of development of sensory compensation for blindness. Miss L.T. is young and I am sure that she still has unrealistic hopes. I think her mother is also unrealistic about her daughter's employment possibilities and this is an explanation of her dissatisfaction with L.'s placement. In any case there has long been evidence of emotional upsets at home which led to L. having considerable feelings of insecurity. The centre staff were able to press successfully for L.'s admission to a local Spastics Hostel but she soon returned home, possibly through parental pressure, which might have had financial overtones connected with the loss of income from L.'s Social Security allowance. The centre does not organise an education programme which could be of great interest to L. and provide a personality boost, too. It is interesting to note that in Miss N.M.'s case, her centre arranges with a local College of Further Education for her attendance at courses of general interest.

Table 5.XI Personal Statistics of 11 People attending "Blind Plus" Centres.

	Age	Vision	Int. H'cap	Phys. H'cap	Beh. H'cap	Deafness	Epi-lepsy	Esti-mated	Actual	Parent
Mr. S.C.	28	PS	A	-	-	-	-	ii	iii	F
Mr. S.Q.	21	PS	A	-	-	-	-	ii	iii	F
Miss B.E.	21	PB	A	-	-	-	E	ii	ii	?
Mr. B.H.	23	PB	A	-	m	-	E	iii	iii	D
Mr. H.E.	26	B	A	-	-	-	-	iii	iii	D
Mr. S.P.	27	B	A	-	-	-	-	ii	iii	F
Mr. E.Q.	27	B	Nil	a	-	-	-	ii	iii	D
Mr. N.U.	21	B	A	-	-	-	-	ii	iii	F
Miss E.Y.	33	B	A	b	-	-	-	ii	iii	F
Mr. B.X.	23	B	B	-	-	-	E	iii	iii	S
Mr. Q.D.	21	B	A	c	-	-	-	iii	iii	S

Comments

(1) I have visited all the centres where there is much more use of simple traditional crafts — basketry, knitting, stool-seating, etc. — than elsewhere.

(2) Three of the centres have quite ambitious ventures aiming to co-ordinate the services for all types of handicapped people, except the mentally handicapped. Although many of the activities are of a social nature and the majority of members

attend occasionally, five day attendance for work/occupation is arranged for appropriate younger adults. One centre has an "industrial" centre similar to some A.T.C.'s, another has recently started a work centre and the third has a woodworking centre.

(3) Seven people had occupation estimates of category (ii). I will deal with them in a multiple case description.

(4) The parents of three people express dissatisfaction with their son's placement. One man will have been dealt with under Comment (3). I will give case descriptions of the other two.

(5) One man has intellectual handicap (B) and I must, to be consistent, give a case description of him.

Case Descriptions of Seven People who had a Work/Occupation Estimate of Category (ii)

Miss E.Y. is physically handicapped. Her hands are fairly useful but she tires rather easily. She can, with great effort, manage to walk about a mile, accompanied by someone, when she is not suffering from chilblains, which she frequently does. Her intellectual handicap is slight and I may well have been mistaken in not classifying her as without this handicap. At school leaving age we thought E. might become a home worker in light basketry. She did not qualify for inclusion in the official home workers' scheme but she carries out a fair amount of good quality work, earning a little money through private sales. For the past three or four years she has spent two days per week at a centre. This certainly gives her occupation and a sense of achievement and makes an important contribution to the pleasant life she leads. She is, in effect, her mother's "companion". I am sure that Miss E.Y. would not manage either open or sheltered employment.

Miss B.E. has good household skills which she showed at Condover so much that we thought she might manage canteen work. She attended a vocational assessment course but has not been found work. She goes to her centre three days per week for "industrial" work and there is a definite possibility that B. may attend the centre full time. A complication is that B. is the eldest of nine children at home and she does a lot of household chores. She is very worried about what she called her "turns" — occasional petit mal attacks — and she is allowed very little independent mobility by her mother who is also worried. A course of rehabilitation at an R.N.I.B. centre could be helpful in developing more independence generally for this very diffident young lady.

Mr. S.P., after vocational assessment immediately after leaving school, was deemed unsuitable for employment. He suffers, to a moderate degree, from abnormal lack of sensory compensation for blindness which hinders practical work. S. attended a centre for several years where the staff thought eventually that he should have a trial for employment so he attended a rehabilitation course, but he was again thought to be unsuitable for work. His own wish is for training and employment as a telephonist. His success would be doubtful, but I feel he should have a trial. His intellectual handicap is minimal, he has fair skill in braille and can type sufficiently well to produce intelligible notes, but not well enough for formal commercial work. He has a pleasant voice and manner, and a good memory.

Mr. E.Q. was promoted from Condover to a school for the blind. He has a physical handicap but showed determination to minimise its effects and managed quite well at the new school. He began a vocational assessment course but during

the course he had a serious illness and was not re-admitted. When I met him in the course of my survey, E. had spent five years at home with little or no occupation. He had just begun to attend a centre one day per week and this has now been extended to three days per week with the prospect of full-time attendance. The centre is fairly new and the staff appear to have enthusiasm and initiative and one hopes that E. will at last receive the vocational assessment to which he is entitled. The Local Authority concerned has a vigorous approach to the question of residential accommodation for physically handicapped people and it would be gratifying to find that Mr. E.Q. could achieve a measure of independent living. His parents express dissatisfaction with their son's situation but, to me, it appears that they took no measures to press for its amelioration.

Messrs N.U. and S.Q. are young and were contemporaries at school. Their post-school experiences have been rather similar too: they did not succeed at vocational assessment courses and they are both at centres where the respective staffs are guardedly of the opinion that they could be employed. Mr. N.U.'s best hope for employment is in assembly or simple light industry and he is getting preliminary experience in these types of work at his centre. He would appear to be a suitable candidate for admission to a sheltered workshop for the blind but there is no such facility in his area. Mr. S.Q. has no parents but is well known to, and cared for by, his Social Services officers. S. would like to take up gardening and does a little greenhouse work in his centre. His vision is very useful and, although his practical abilities are restricted, one would think that some selected occupation could be found for him in a local authority's gardening and out-door staff.

Mr. S.C. came to Condover for the last six months of his school career. He went on to one of the vocational assessment courses but suffered an accident there with a machine, losing the top joint of a finger and seems to have lost confidence in his ability to work. He attended a residential centre but eventually ran away from it. He returned home to his parents but when he was given the opportunity to attend a day centre, he often absented himself while giving his parents the impression he was still attending. He began attending his present centre when it opened about two years ago and at last he seems happy and settled. S. carries out some work, mainly of handicraft type, and also has official and semi-official messenger duties. The staff feel that Mr. S.C. has some employment potential, their main doubt being about the young man's ability to stick at a repetitive job. I suspect that S. is not keen to try employment.

Two People whose Parents are Dissatisfied with their Son's Placements

In Mr. H.E.'s case I think that the difficulty is, yet again, abnormal inability of sensory compensation for blindness. H. is moderately affected by this, particularly in manual activities. His independent mobility thanks to specialised training, which is rarely available for Condover ex-pupils, is surprisingly good. H.'s parents feel that their son is capable of more than the diversionary occupation which he is carrying out. Fortunately a new development in his centre may be helpful where he now attends a newly established work-orientated department within the centre. This is for younger, more able, members of the centre so that they are no longer associated with the mainly pastime occupations of the other members.

Mr. B.H. is more able manually than Mr. H.E. and his parents are probably correct in feeling that their son could do more work. B. has, however, a behaviour handicap which shows itself in bouts of obstinate non-co-operation and irrespondibility, which make it difficult to think of him undertaking open or sheltered employment. Perhaps his centre could develop a special form of Sheltered Workshop within its facilities?

One Person with Intellectual Handicap (B)

Mr. B.X. was transferred to his present centre from an A.T.C. He is the only ex-pupil from whom, as far as I am aware, there existed the simple alternative of attendance at an A.T.C. or an Other Day Centre, both quite close to home. I saw B. at the A.T.C., where he seemed well settled. I have visited his Other Day Centre but this was before he began to attend, and I can understand that he will be well settled there, too. He will have less work, but more social activities. The parents, no doubt, feel that their son is no longer classed as "mental".

N.B. A résumé of the above evaluations is given in the Summary and Recommendations section at the end of the chapter.

Two Special Sub-groups

Table 5.XII Personal Statistics of Three People who Attend Hospital Occupational/ Industrial Therapy Units.

	Age	Vision	Int. H'cap	Phys. H'cap	Beh. H'cap	Deafness	Epi-lepsy	Esti-mated	Actual	Parent
Mr. K.R.	28	B	A	-	m	d	-	i	iii	D
Mr. O.U.	23	PS	A	-	m	-	-	ii	iii	D
Mr. S.V.	32	B	A	-	m	-	-	iii	iii	D

All three men live in their parents' home and attend the units daily.

Mr. K.R. made good progress at school and was transferred at school leaving age to a vocational assessment course. It was hoped that he would be recommended for employment, but, during the course, he had an unexpected but quite severe nervous breakdown and had to be admitted to a hospital for the mentally ill. K. was one of the first ex-pupils I visited in my research survey. He was then, at the age of 25, living with his mother and step-father, but attending daily the Occupation Therapy Unit of a hospital where he had previously been an in-patient. He has had treatment at three hospitals and at one time was diagnosed as suffering from mild schizo-phrenia. I found K. much as I would have expected him to have been if he had not suffered the breakdowns, except that he was rather more withdrawn and diffident. He was doing quite well in the assembly work carried out in the unit and the staff felt he should attend a centre or a sheltered workshop in the community. At this time, early in my research, I felt that I should try to ameliorate ex-pupils' conditions by making reports and recommendations, a project which I had to abandon because of lack of time and the snowballing effect of starting something moving and being re-involved. In K.'s case I approached his psychiatric consultant who said he would be pleased to co-operate with Social Services. I told the Director of Social Services of this and pointed out that there is a Sheltered Workshop for the Blind in the neighbourhood. I know that the appropriate Area Social Services office were informed, but, three years later Mr. K.R. still attends the hospital unit and, to the best of my knowledge no action has been taken. Hence the parent's dissatisfaction with K.'s situation.

Mr. O.U. had a behaviour handicap at school which I ranked as (m). This showed itself in a difficulty in establishing personal relationships and an inability to accept criticisms of his behaviour. He did not succeed at his vocational assessment course and subsequently found neither employment, nor occupation in a centre. These difficulties appear to have reversed the improvement in behaviour which we had noted towards the end of O.'s school period. He became increasingly withdrawn, unco-operative and occasionally aggressive. O. and

his parents consulted a psychiatrist and O. began to attend the Industrial Therapy Unit where he still is more than two years later. He carries out effectively the packing and assembly work at the Unit, but the period of rehabilitation has lasted longer than the parents had expected and there appears little likelihood of O. finding employment with Remploy which was once suggested. No alternative centre or work alternatives have been suggested. I think the young man is reasonably satisfied with his present situation especially as the hospital staff use his considerable gifts as a pianist as a social aid to other patients, but I think a course of rehabilitation is advisable.

Mr. S.V. has less skills in practical work than the other two men. His behaviour handicap at school was often near (M) rather than (m). I think it is unlikely that he could be found a better placement than his present attendance at the hospital Occupational Therapy Centre.

Table 5.XIII Personal Statistics of Three People Attending the Elizabeth Gunn Centre.

	Age	Vision	Int. H'cap	Phys. H'cap	Beh. H'cap	Deafness	Epi-lepsy	Esti-mated	Actual	Parent
Mr. E.D.	30	PB	B	a	-	-	E	iv	iv	S
Mr. U.L.	21	PB	A	c	-	-	E	iv	iv	S
Mr. V.D.	20	B	C	a	M	-	E	iv	v	S

I need not give any case descriptions but I point out how severely multi-handicapped these three men are. I will, however, give a fairly lengthy account of the Elizabeth Gunn Centre which provides an almost complete set of services to its multi-handicapped blind adults.

The Elizabeth Gunn Centre

This Centre is administered by the Birmingham Royal Institution for the Blind and has accommodation for 30 multi-handicapped blind adults with an outwork service for 20 people who are unable to attend the centre. Developments in the centre have taken place during a period in which considerable changes have occurred in the Institution. Certain facilities which were founded and administered for many years by the B.R.I.B., were taken over by local authorities. The City of Birmingham is now responsible for the Sheltered Workshop while Blind Welfare and the Home-Worker schemes are run by various local authorities. The Institution has, however, maintained its interest in all aspects of blind welfare with direct responsibility in certain matters. It has its own small but flourishing Adult Welfare Department, an important feature of this department's activities being the Occupation Centre.

The original centre, opened in 1952 for two multi-handicapped men, grew slowly in size and for twelve years was troubled by accommodation problems. Fortunately, during a period of crisis in the early and middle '60's, an unexpected legacy arrived from Miss Elizabeth Gunn, who wished £12,500 to be devoted to the interests of multi-handicapped blind people. This money, which was augmented from the B.R.I.B.'s funds, led to the opening in 1967 of the purpose-built centre which is known as the Elizabeth Gunn Occupation Centre. It is the only day centre in Britain specialising exclusively for visually handicapped multi-handicapped blind adults.

In early 1974 the centre had 28 members, aged from 19 to 57 years, whose handicaps are very similar to those of Condover ex-pupils, though only four members actually attended the school. The presence of these four people, one of whom now attends the nearby Sheltered Workshop, was, however, useful in estimating

the handicaps of all the members of the centre and relating them to the handicaps of the whole research group. To help this comparison, Table 5.XIV has a third line showing the incidence of handicaps to be expected in an averagely representative group of 28 ex-Condover pupils, the figures here having been obtained by the simple arithmetical exercise of finding 28/314ths of the total research group.

Table 5.XIV Comparison of Handicaps, Elizabeth Gunn Members - Condover Ex-Pupils.

		Condover (314)	Elizabeth Gunn (28)	Condover (28)
Vision	PS	75	7	7
	PB	102	11	9
	B	137	10	12
Intellectual Handicap	Nil	61	4	5
	A	129	11	12
	B	82	7	7
	C	42	6	4
Physical Handicap	Nil	220	18	20
	a	31	2	3
	b	36	5	3
	c	27	3	2
Behaviour	Nil	207	19	19
	m	68	7	6
	M	39	2	3
Epilepsy	-	65	6	6

Comments

(1) The table shows that the Elizabeth Gunn Centre deals with a group of multi-handicapped people remarkably similar to the former Condover pupils.

(2) Many of the activities of the Elizabeth Gunn Centre are similar to those of Adult Training Centres, such as occupation, education and club meetings.

Integration of Services at the Elizabeth Gunn Centre

This integration arises from the particular way in which the B.R.I.B. has developed. Although it may not be possible to reproduce the pattern elsewhere, the Elizabeth Gunn Centre procedures present certain growing points which could indicate the way to developments elsewhere in the services for multi-handicapped people.

The B.R.I.B. is responsible for a Day Rehabilitation Centre which serves Birmingham and surrounding areas. This centre is quite close to the Occupation Centre so that its members are able to make use of the Rehabilitation Centre's staff for instruction in Mobility, Homecraft, Braille, Moon, and Typewriting. All the members of the Occupation Centre's staff have duties also in other sections of the Institution's welfare services. The staff and members of both centres take their mid-day meal in the Elizabeth Gunn Dining Room and, incidentally, so do the Institution's general Secretary and its Welfare Supervisor. Undoubtedly a remarkably effective integration is produced on a very practical, though informal basis. It should be added that some members of the Institution's Adult Welfare Committee are personally interested in the Centre and know the members of the Centre as individuals and there is also an effective Parents' Organisation.

There are now no official routine contacts between the B.R.I.B. and the City's Sheltered Workshop. However, the Workshop and the Elizabeth Gunn Centre are close to each other and this has facilitated assessment and trial working

periods in the workshops for the more capable Occupation Centre members and five former members of the centre are now employed in the workshop. Here, in Birmingham there is the geographical proximity of an occupation centre and a sheltered workshop with occasional co-operation. Perhaps, elsewhere, small occupation centres could be developed within, or in the neighbourhood of, most sheltered workshops?

The Elizabeth Gunn Staff policy concerning admissions to the centre is to give careful and sympathetic consideration to all multi-handicapped blind adults for whom daily attendance is possible. The only people excluded from attendance are those who are too capable to warrant admission and those extremely severely handicapped people who might be a source of danger to themselves or others. The centre has established a precedent of admitting some more able blind people previously resident in Hospitals for the Mentally Handicapped, three such people now being members of the centre. Two of these people live in their parents' homes and the third lives with the parents of another member of the centre.

Summing up:- the Elizabeth Gunn Centre is at the heart of a type of continuum which provides for multi-handicapped blind people possible progress from hospital to sheltered employment with a stable provision of occupation and social experience for the majority who have no likelihood of employment. Occupation is also provided for home-bound severely handicapped blind people. The most important deficiency in provision is the lack of residential facilities, though the possibilities of establishing some type of hostel accommodation are being actively considered by the B.R.I.B. committees.

Miscellaneous Information

Mobility

The information which follows was gathered from ex-pupils' personal questionnaires. There were two levels of enquiry — the extent of independent walking and of independent use of public transport — and these have been expressed in five grades of achievement.

57 Ex-pupils in A.T.C.'s (Three people did not reply.) Training in mobility has only been provided for three, or possibly four, people.

Grade 1:- use of long distance transport plus walking at least two miles. Only the very unusual person, Mr. L.Q., who is partially blind, achieves this very high level of mobility.

Grade 2:- use of local transport plus neighbourhood walking. Eight people achieve this good standard: five partially sighted, two partially blind, and the totally blind, physically handicapped Mr. E.Q. who is by far the most intelligent person in the A.T.C. group.

Grade 3:- no use of transport, but walking at least two miles. (This high limit of walking is unrealistic for city dwellers, though many people managed it in the Condover area.) One partially sighted man and one partially blind man achieve this standard. Both refuse to use transport unaccompanied.

Grade 4:- neighbourhood walks, but no use of transport. 16 people achieve this standard: four partially sighted, nine partially blind, and three blind. No training in use of public transport was given at Condover because of the infrequency of the country 'bus service. Of the 16 people, I consider that eight could easily learn to use local transport. The other eight, because of their physical handicaps, could not gain this level of independence.

Grade 5:- never leave home unaccompanied. Thirty people are in this group. For 15 people this is a necessary restriction: three are deaf-blind, five have severe physical handicaps, and seven have difficulties of personal behaviour. For the other 15 people the restriction of mobility seems unnecessary, 12 of them having achieved personal independence in Condover village as part of the school's mobility training scheme. None of the 15 lives in the heart of a city and all could begin with short walk training near home without having to cross a road. Two of the 15 are partially blind, 13 are blind.

10 People in Centres for the Physically Handicapped No mobility training is provided.

Grade 1:- none; Grade 2:- one partially sighted; Grade 3:- none; Grade 4:- one blind; Grade 5:- total eight. Four partially blind and one blind are correctly graded because of physical handicaps; three blind people could achieve some independence since all attained village independence at school.

11 People in "Blind Plus" Centres Mobility training is available.

Grade 1:- one partially sighted; Grade 2:- one partially sighted, one partially blind, and two blind; Grade 3:- none; Grade 4:- one partially sighted two blind; Grade 5:- three blind; two correctly placed because of physical handicap but one could achieve some independence (he was independent in the village at Condover, but at that time he had some useful vision).

Three People in Elizabeth Gunn Centre Mobility training is available.

One man achieves mobility at Grade 2, but his use of public transport is confined to occasional journeys between home and centre for which he has been carefully trained. The other two men are correctly placed in Grade 5, one because of severe physical handicap and the other because of both physical and behaviour handicaps.

Three People in Hospital Units No mobility training available.

One partially sighted man is at Grade 2 and one partially blind man at Grade 4, both these achievements being satisfactory. The third man, now at Grade 5, needs help urgently since, at school he was one of our most proficient blind pupils.

Comments

(1) It is disappointing to find that 20 people who, at school, were independently mobile in the village, now never leave home alone. Of these 20 people, 17 are blind!

(2) In these times of shortage of trained mobility officers, occasional advice from experts to staffs of A.T.C.'s and Centres for the Physically Handicapped could help the staff to re-establish the mobility of the ex-pupils concerned.

Literacy

59 People in A.T.C.s I lack information about one person. Statistics for the 59 are:- 44 are completely illiterate; five make very minor use of reading and/or writing (two braille, three print), six make more use of reading and/or writing, e.g. sports fixtures, magazines, simple letter writing (five braille, one print); four are real readers, in that they claim to have read at least four library books in the past year (two braille, one large print and surprisingly,

one person uses Moon type which he has learned since leaving school — Moon is usually learned by elderly people).

Talking Books:- 12 people make much use of these books, reading at least six books per year. One person also reads braille, all the others doing no other reading.

Three People at Elizabeth Gunn Centre All are illiterate. One man claims to have read four talking books in the last year.

24 People at Other Day Centres There is no need to differentiate between the other types of centres, so I combine the statistics thus:- seven are completely illiterate; five make very minor use of reading and/or writing (three braille, two print); six make more use of reading and/or writing (five braille, one print); six are readers of library books (four braille, two large print).

Talking Books:- eight make much use of talking books. Two of these are braille readers, four make occasional use of braille or print, and two do not read at all.

Domicile

77 ex-pupils live in the home of their parents or of a near relative.

Six people in A.T.C.'s have hostel accommodation: four are well situated in Local Authority hostels associated with their centre; two have a rather unsatisfactory placement of an emergency nature.

Four people in Other Day Centres have hostel accommodation; three are well situated in hostels associated with their centres (two administered by a Local Authority and one by the Spastics Society); one has a rather unsatisfactory placement in a hostel for the mentally handicapped.

Further discussion of the domicile question will be found in a special section of Chapter 9.

Summary and Commentary

Introduction

This chapter has been a discussion of the two main types of day occupation centres: Adult Training Centres for the Mentally Handicapped and Other Day Centres for the Physically Handicapped. The A.T.C. is the more fully developed of these two services, the provision of facilities covering approximately one half of the national need. The Other Day Centre service, catering for all types of physically handicapped people who are not mentally handicapped, requires to be developed very considerably. The A.T.C.'s provide programmes of occupation for five days per week for their members plus some specially adapted courses of Further Education and social activities. Some Day Centres for the Physically Handicapped provided similar occupation programmes to those of the A.T.C.'s. Day Centres for the Blind, or for the Blind and Physically Handicapped combined, tend to be geared to the needs of the elderly although there is some development nowadays of five days per week occupation for adults of "working age".

Summary of Evaluation of Placement

A large part of the chapter has been devoted to the evaluation of the present placement of Condover ex-pupils in centres for the mentally handicapped and centres for the other types of handicapped people. The upper limit of mental handicap is not easy to define in terms of the severity of intellectual and behaviour handicaps. The position of multi-handicapped visually handicapped people is difficult to assess, especially of those who have no intellectual handicap or who have only a moderate one, but who are incapable of achieving employment. Should they attend A.T.C.'s or Other Day Centres? Because of the lack of centres, particularly Other Day Centres, this has been a theoretical question for many ex-pupils, for whom the choice has been between an A.T.C. and staying at home with little or nothing to do. One other question needs to be asked: are there any people who are capable of employment but, because of lack of training or rehabilitation or availability of jobs, have to attend a day centre? My enquiry into these matters is summarised thus:-

60 ex-pupils in A.T.C.'s With two exceptions there is no alternative choice of an Other Day Centre at present. If they wish to have some form of occupation five days per week, an A.T.C. is the only facility available. Apart from one man who wishes to cease attending an A.T.C., all the ex-pupils and the parents accepted the A.T.C. placement voluntarily.

Under present circumstances I consider that most of the 36 people with intellectual handicaps (B) and (C) are well placed in A.T.C.'s since they are of the same intellectual level as the sighted members of such centres. If Other Day Centres with facilities for the blind were available, a few of the totally blind ex-pupils — not more than four — might be better placed there.

The situation with the 24 ex-pupils whose intellectual handicaps are Nil or of category (A) is somewhat different. I consider that nine are correctly placed in an A.T.C. and would not need to be transferred even if an Other Day Centre were available. Ten are satisfactorily placed now and, although they might be more suitably placed in an Other Day Centre, the need for transfer is not urgent. For five people the present placement should be reviewed as an emergency measure. Placement into open or sheltered employment is urgent, either directly or after a period of rehabilitation with re-assessment of their employment potential.

21 ex-pupils in Other Day Centres All these placements are satisfactory, except that one man who attends a Centre for the Physically Handicapped needs treatment as a seriously mentally handicapped person.

After helpful experience and training in their respective centres, three men definitely require assessment of their employment potential with a course of rehabilitation. A fourth man, about whom I feel less certain, should have re-assessment for training as a telephone operator. A young woman needs a rehabilitation course for social reasons rather than for employment.

Some Notes on Handicaps

Visual Handicaps My enquiries generally, and the discussions of this chapter in particular, have brought home forcibly to me the special needs of those people who are totally blind or have such small amounts of vision that it is of very little practical help, i.e. the people whom I have classified as (B). Nowadays, when the general term 'visually handicapped' is so much used, it is necessary to emphasise that the problems of the partially sighted and the partially blind are different and less acute than those of the blind.

Classification According to Effects of Handicap I am still unable to decide to what extent visual and physical handicaps which contribute in some people to a serious lack of development should be considered to be a mental handicap. It is important to consider the effects that handicaps can have on such things as manual ability, independence, education and personality. For instance, handicapped people could be graded according to general occupational handicap or degree of independence. The same grade of occupational occupation would include a wide variety of the sensory, intellectual, physical and behavioural handicaps. One could then think in terms of the services which centres could provide for these more "functional" handicaps. This could apply to the whole range of handicaps though I am thinking especially of the placement of visually multi-handicapped people with minor or no intellectual handicaps, but who have quite severe occupational handicaps and poor independence. When a full service of day centres is available these people should be able to choose the centre they would like to attend, after preliminary trials if necessary.

The Day Centre Service

This service provides facilities for seriously handicapped people who suffer from various handicaps which can be broadly classified into two groups: those which constitute a mental handicap and those which do not. The range of abilities varies from a minority who are on the borderline of needing hospital care to a minority who could be helped to find employment. Many more A.T.C.'s and Other Day Centres are needed, though I have some misgivings about the division into the two types of centre. I suppose there are good arguments for the continuation of the dichotomy, but I would like to see some increase in the already existing tendency to merge the two types somewhat by interpreting the border between mental handicap and physical handicap liberally in favour of individuals' needs. I see no need to devise completely new types of Day Centres, but rather to extend the number of centres available, developing, modifying, and sometimes combining the present facilities. I give a few comments and suggestions.

(a) Recent changes in local authority boundaries have placed four A.T.C.'s, fairly close geographically, under the direction of a new Local Authority. The staff of one of these centres, which, incidentally, is one of the liveliest and most effective which I have visited, would like to see the functions of the four centres adjusted thus: one A.T.C. would act as an assessment centre, two would carry on as "ordinary" A.T.C.'s, while the fourth would be a work-orientated establishment as a kind of half-way house between an A.T.C. and sheltered or open employment.

(b) I have visited three Local Authorities where an Other Day Centre is an important part of a Social Centre where there is considerable development of educational, social, recreational and sporting activities available for all the handicapped people of the area except the mentally handicapped, with some efforts being made to incorporate the handicapped in the general activities of the town and to obtain voluntary help within the centre.

(c) In small Local Authorities and in rural areas, where travel between home and centre can be very lengthy, it seems reasonable to establish multi-purpose day centres with departments for the mentally handicapped and for the physically handicapped. Such centres may already be in existence but I have not heard of any. It would be well worth experimenting with the addition of an Other Day Centre to an existing A.T.C. or vice versa.

(d) The ultimate aim should be the development of Day Centres which are accepted by the people in the area as community amenities and receiving the support of the community in such things as the supply of work contracts from neighbouring

factories, of the involvement of the handicapped people, where possible, in community activities, and as an outlet for that desire for voluntary service which is shown by some organisations and many individual people.

A Miscellany

Some Practical Suggestions to Staffs of Centres

These suggestions are made with some diffidence since I am almost completely an onlooker with no experience in the running of day centres. Nevertheless I have had many years experience with children and young adults who were seriously handicapped.

(a) General

(1) Would it be possible to organise regular meetings of all the members of the centre? This could be a weekly formal assembly in which news concerning the centre is made public, recognition is made of good effort on the part of members, announcements concerning events and functions are made, etc. Although this may seem a rather formal or artificial procedure, I am quite sure that its unifying function is of great value and can have considerable educational and social benefits.

(2) I know that many centres hold staff meetings. Would it be possible for staff meetings to become a formal regular procedure? The agenda could include discussion of all centre business and a case review of members on a periodic basis. The case reviews could easily lead to positive action aimed to help individual members.

(3) I have seen two or three centres where good liaison between Social Services and the centre is established with good practical results. In other centres I have been aware of criticism by staff of lack of liaison with Social Services. Would it not be possible to have some formal liaison procedure between centres and Social Services? If staff meetings are held, a social worker could perhaps attend these meetings or a selection of them.

(b) To Centres who have one or two Visually Handicapped Members but no members of Staff with Training or Experience with Visually Handicapped People

(1) Read the section on Visual Handicaps in Chapter 2.

(2) Some Social Workers are taking specialised training in the needs of visually handicapped people. The help of a specialised social worker should be sought. No doubt in many cases such a specialist is not yet available, but the need for such help should be re-stated from time to time.

(3) The Royal National Institute for the Blind has an Educational Advisory Service and an Employment Placement Service. Application to the Institute could well lead to a visit to a centre from an officer from one of these services or from the Careers Officer of Condover Hall School.

(4) If no specialist advice is available, much can be done by staff with no specialised experience. Common sense, ingenuity and good rapport with the visually handicapped person are the main requirements. I offer the following suggestions:-

In mobility, although sometimes it may be helpful to be ahead of a blind person to indicate the way, in general the instructor should be behind the subject helping him to "hear the way and feel it with stick and feet". If the subject is blind, take him along a path or corridor and let him tell you the objects and obstacles he "hears". In unusual situations let the blind person explore ahead of you and see what he can find

In education programmes, consider the use of school radio programmes. Give the visually handicapped person the opportunity to show what he can do, particularly in homecraft. Don't pre-judge the situation by deciding that some operation is impossible, be prepared to take a few minor risks.

Education

Although the A.T.C.'s vary in their methods and their programmes, there is considerable emphasis in the majority on education and social experiences as well as the provision of occupation. The educational programmes are of great importance to the members, many of whom having matured somewhat since leaving school, seem ready for general educational opportunities based on social and practical needs. Some Local Authorities provide evening classes for selected mentally handicapped people.

Although some Other Day Centres provide education programmes there is little uniformity in planning between centres. It may be that it is thought that most members of these centres are of sufficiently high intelligence that further education is unnecessary and it is not a function of the centres, particularly those who act as work centres, to provide education. However, young adults whose occupation potential is low because of their handicaps, could profit from specially planned education programmes in, or based on, their centres. If the members can attend evening classes with non-handicapped people, this is an excellent idea.

Occupation - Employment - Payment

Although here I am emphasising the occupation aspect of centres, it should be remembered that the majority of members have very little employment potential and the success of a centre is largely measured by the quality of the life it provides for its less able members. Nevertheless, the success gained by a few more capable members can have a good effect on the centre generally. For these more capable members some improvements are necessary to enable more people to gain open or sheltered employment. These suggestions for improvement are important enough to be included in the recommendations which follow below, i.e. (2b), (2c), and (2d).

Recommendations

(1) Future Placement of Visually Handicapped People who need Day Centre Treatment

(a) Centres for Blind People are suitable for non-mentally handicapped people but a full week's occupation is advisable. Combined Centres for Blind and Physically Handicapped People offer better opportunities for programmes for such people since more people of this age would be available. The sight of the physically handicapped and the manual ability and the mobility of the visually handicapped are complementary, making a wider range of occupation possible.

(b) Consideration should be given to the development of specialist centres for the visually multi-handicapped on the lines of the Elizabeth Gunn Centre, but adding some sighted people, or of departments of this type within large Day Centres.

(c) It is likely that the majority of visually handicapped people will be placed in A.T.C.'s and Other Day Centres among sighted people. This should not be regarded as an unfortunate expedient but as a positive policy.

(d) Regardless of the type of centre in which they are placed, the visually handicapped should receive the specialist services to which they are entitled and, where necessary, this should be extended to cover their home life. In A.T.C.'s and Other Day Centres not specialising with the visually handicapped, the staff need the advice of specialist officers trained in the mobility and other practical aids for the visually handicapped, especially the blind.

(e) The specialist officers referred to in (d) are employees of Local Authorities and are in short supply. The Royal National Institute for the Blind should be asked to extend its Educational Advisory Service, making advisers available to Social Services Departments and Day Centres.

(2) Recommendations Concerning All Types of Handicapped People in Centres

(a) Serious handicaps have a marked retarding effect on educational progress and many school leavers, including the most seriously handicapped, have reached a stage when they would profit greatly from further education adjusted to their special needs. Day Centres should give educational opportunities in the centres or, for some members, help to initiate special courses elsewhere, e.g. day release or evening classes.

(b) The ceiling payment for earnings for people on Social Security should be raised from £2.00 to £6.00. The total for Social Security grants plus £6.00 would then be approximately equal to half the wages paid in Sheltered Workshops. The payment for earnings should be at the accepted rate for the job.

(c) The most likely employment destination for centre members is a Sheltered Workshop which may be for the Blind, for the Physically Handicapped (or for these two combined), or for the Mentally Handicapped. Some kind of half-way stage between centres and sheltered workshops should be developed. For some people this half-way stage might be a permanent placement, but the main objective would be the transfer of people to employment. It could be a separate establishment or an 'enclave' either within a Centre or a Workshop.

(d) Discussions are taking place on the future of Sheltered Workshops. One important decision to be taken is whether responsibility for the workshops should remain with the Department of Employment or be transferred to the Department of Health and Social Security. If responsibility remains with the D.E.P., good liaison should be maintained between Local Authority Social Services, local offices of the D.E.P., the management of Workshops and the Trade Unions to which workers belong.

(3) The Day Centre Service

(a) Social Service Departments should promote liaison and consultation between Hospitals and Day Centres; between Day Centres and Sheltered Workshops; between Staffs of Day Centres in their area; and between Administration, Social Workers and Staffs of Centres.

(b) Serious consideration should be given to some merging of the A.T.C.'s and Other Day Centres.

(c) Much more finance should be provided so that Social Services can proceed with the setting up of the great increases which are needed in the following facilities, which are presented in what I consider to be their order of priority:- Hostels, Other Day Centres, A.T.C.'s.

CHAPTER 6

RESIDENTIAL FACILITIES

Review of Contents of Chapter

This chapter deals with 50 ex-pupils who live in a variety of residential establishments. For convenience I have included one other ex-pupil who, although non-resident, attends the educational programme of one establishment.

Section A describes three establishments which specialise in the care of visually handicapped adults:-

The Wilberforce Home for the Multiply Handicapped Blind where eight ex-pupils are among the total of 20 residents. The close co-operation which has existed between Condover and Wilberforce since the latter opened has continued in that its Staff and Committee have been interested and very helpful in my research. The Royal School for the Blind, Leatherhead, where 30 ex-pupils are among the total of 200 residents. I acknowledge the help of the Principal, who read and commented upon the section dealing with his school, and of other staff, especially those of the men's occupation's departments, who made my visits to Leatherhead interesting and informative.

Greenside, a department of Christopher Grange, with which I have had happy associations since its opening, has two ex-pupils among its 14 residents.

Section B deals with 11 ex-pupils who are resident in hostels which do not specialise with the visually handicapped. These ex-pupils live in different hostels where they are the only visually handicapped persons among the residents. With one exception I have visited all these hostels, the exception being one which was visited informally by a friend and with the staff of which I have had several friendly telephone conversations. The staffs at these establishments were helpful and co-operative.

SECTION A Residential Establishments Specialising for Blind People

The Wilberforce Home for the Multiply Handicapped Blind

The Yorkshire School for the Blind was founded in 1833 by public subscription as a memorial to William Wilberforce - that great campaigner for the abolition of slavery.

During the years from 1833 to 1964 the School provided services for the blind such as education, training for sheltered employment and administration of workshops for the blind. In 1964 the School's final function - a hostel and training centre for blind boys and girls - was closed in consequence of a policy decision by the Ministry of Education.

In these circumstances the Yorkshire School for the Blind approached the Department of Health and asked whether there were any essential needs of the blind which could not be filled by Local Authorities. The Department told them that they were most interested in the possibility of starting a residential home for 20 multiply handicapped blind persons for whom there had hitherto been no provision beyond Condover Hall School. It would give a refuge, in company with others in the same circumstances, for blind persons who are in need of care and stimulating activities but who are so severely handicapped that they cannot be employed in Workshops for the Blind.

The number of these blind severely physically handicapped persons is limited - there may, for example, only be one or perhaps two in the area of a Local Authority and it is therefore not possible for Local Authorities to provide the special residential accommodation and other facilities which they need.

The Yorkshire School for the Blind accepted this unique project. It may be regarded as a continuation and development of its pioneering work since 1833. Its Chairman and Secretary then visited a considerable number of Homes for the Handicapped in the course of which they became particularly interested in Condover Hall School, Shrewsbury. The pupils of this School included blind children with additional serious physical handicaps whose care would present problems too great for their parents to be expected to cope with at home. These children had to leave the School on reaching the age of 16 and, thereafter, there was no suitable residential Home to receive them.

On the opening of the Wilberforce Home in August, 1969, there were four residentsfrom Condover Hall School. Since then that number has increased to 12. A close and happy contact now exists between the Wilberforce Home and Condover Hall School.

The Wilberforce Home accepts residents not only from Yorkshire but from the whole of the United Kingdom. They, therefore, in undertaking these new responsibilities adopted the name of The Wilberforce Home for Multiply Handicapped Blind (formerly The Yorkshire School for the Blind). This very specialised service is costly to maintain and the annual fee charged to Local Authorities is £2,200 per resident (in 1974).

With considerable financial help from two Trusts the committee supervised the building of a specially designed residence for 20 seriously physically handicapped blind people which was opened in 1969. Each person has a bed-sitting room with sufficient space for the comfortable use of a wheel chair with built-in furniture specially designed for physically handicapped people. All possible mechanical aids for bathing and toiletting are provided so that the residents can be as independent as possible. By the end of 1974 the facilities will have been extended to the maximum considered desirable. There are three sitting rooms, a spacious workroom and a therapy pool sufficiently large to allow some restricted but, nevertheless, effective and enjoyable swimming.

The Committee and staff aim to provide a home or community with sufficient activities and stimulation commensurate with the abilities of its residents, and to encourage them to take responsibility for their own lives as far as possible. Blind people with additional serious physical handicaps are admitted. Some in addition are considerably intellectually retarded but with an I.Q. above 50 and a few have moderate behaviour problems. People with such a high degree of behaviour problems that the community atmosphere would be seriously disturbed are not acceptable.

Eight Condover Ex-Pupils at Wilberforce

With such severely handicapped people the factors of mobility, self-care and occupation are of great significance, so I will discuss these topics first.

Mobility

Among the eight people there is only one person who can walk alone without support of any kind for more than a few yards. Actually she could walk two or three miles without support, though she has a marked limp. She would, however,

need supervision. One other person can walk with a little help from a helper and could probably manage two or three miles in this fashion. All the other six, five of whom are totally blind, have to rely on the use of a wheel chair for any movements beyond a few yards. While they are able to wheel themselves independently within the specially designed rooms and corridors of their Home and can venture out on the flat paths in its grounds, none of them can use their chairs independently in the street. They are completely dependent for any journey away from the Home.

Occupation and Self-Care

Although these young men and women are encouraged to be as independent as possible, their handicaps create for them a high degree of dependency, which is demonstrated very clearly in the matters of occupation and self-care.

The Home has a 5-day week occupational therapy service with two full-time members of staff and a well appointed workroom. The main activities in the workroom are mosaic tiling, simple basket work, stool seating and rubber-link mat-making. In addition there are courses in cookery, simple metalwork and pre-pottery exercises, but there is no repetitive contract work. There is an informal programme of oral English, current affairs, etc. The therapist in charge provided me with an estimate of each of the eight people's performance based on variations around the average for all people attending the workroom. I have been able to relate this to the Occupational Estimate score which I am using in the whole research survey.

I have also attempted to compare self-care scores at present with those at school. This has posed certain difficulties since I was trying to correlate school staff estimates of children with scores for adults and there were not many easily identifiable similarities in the bases for estimating. There has, therefore, been a considerable amount of my personal opinion in making the comparison. I have converted school scores into the general five-point scale on which the Matron of Wilberforce, on my suggestion, has estimated the eight people's abilities in Dressing, Washing and Bathing, Personal Appearance, Eating and Toilet. The scale was (a) completely independent, (b) nearly independent, (c) needs help with a few things, (d) needs frequent help, (e) completely dependent. I then averaged the present scores to give a general estimate for self-care.

In Dressing, with the exception of one person rated as (b) all others were scored (d) and this was the only skill in which I thought there might be a deterioration since school days. The scoring for Washing and Bathing was exactly similar but the reason for the low scores is the inclusion of Bathing with Washing, most people being able to perform the latter skill adequately, but having considerable difficulties with bathing. Personal Appearance is somewhat difficult to define and there are obvious variations between men and women so I simply report that one person is ranked as (b), four as (c) and three as (d). With regard to Eating, one person scored (a), 5 (c), and 2 (d). For Toilet management three are completely independent though it should be remembered that there are special adaptations for the W.C.s including an electric warm water flush and dryer to obviate the need for toilet paper. Two people scored (c) and three (d).

A summary of the above information, as it relates to each individual, is given in Table 6.I., which also includes statistics about individuals' handicaps.

Self-care scores: (a) completely independent, (b) nearly independent, (c) needs help with a few things (d) needs frequent help, (e) completely dependent.

Mobility scores: as for self-care, but I add guide lines for the three most dependent categories: (c) can walk about a mile in a well-learned environment, (d) can walk about a mile supported by a helper, (e) needs a wheel chair for any movement of more than a few yards.

Handicap scores are discussed in Chapter 2 and a summary is given on page 24, a copy of the latter being printed on the marker.

Occupation Estimates: the scores in brackets are the original estimates, the other numbers indicating levels of present performance.

Table 6.I Personal Statistics (N=8. Age range 20-29)

	Vision	Int.	Phys.	Beh.	Mobility	Occupation		Self-care	
Mr. C.C.	PB	B	c	Nil	e	iv	(v)	d	(d)
Mr. D.T.	B	A	c	Nil	e	iii	(iii)	d+	(c)
Mr. K.U.	B	Nil	c	Nil	e	iii	(iv)	c	(d-)
Miss P.C.	B	A	c	Nil	e	v+	(v)	c-	(c)
Miss N.I.	PB	B	b	m	e	iv-	(iv)	c	(c)
Miss M.T.	B	B	c	Nil	e	v	(v)	d	(c-)
Miss E.R.	PB	B	b	Nil	c+	iv	(iv)	c	(b)
Miss Q.Y.	B	A	b	m	d+	iv	(iv)	b	(c)

In a normal context the changes in abilities in occupation and self-care would be almost insignificant, but in the cases of some of these severely multi-handicapped people, the personal effect is quite marked. I add, therefore, these notes on individuals.

Mr. C.C., has always suffered from epilepsy and an indication of its severity is that for some years it was thought advisable that he should wear a padded helmet to prevent damage to his head when, as happened frequently, he fell forward in the course of a fit. About a year ago there was a sudden serious increase in his epilepsy and he was admitted to hospital as an emergency case. Treatment there has made a great improvement in Mr. C.C.'s condition, his fits being much less frequent. There appears to have been an associated improvement in his general condition, which is probably shown by his improved performance in the activities he carries out in the occupational therapy work room.

Mr. D.T. suffers from a form of ataxia which has increased in severity since his school days. His mobility has declined so that he is definitely in category (e), but, rather surprisingly, he has retained his abilities in occupation and self-care.

Mr. K.U. has shown a slow improvement in manual performance which he attributes partly to the after-effect of an orthopaedic operation which took place at school leaving period. K. says that the surgeon told him that the improvements after the operation would be very gradual and he considers that the chief beneficial effect has been a return of feeling to his legs. There have been no spectacular changes in his physical condition - and none were expected - and K's improved performance in occupational therapy and in self-care may be due as much to his continuing personal efforts as to any physical change.

Miss P.C. has a history of epilepsy but this is no longer active. Three intelligence tests, widely spaced in time during her school days, all placed her firmly in the category (A) of moderate intellectual handicap. At times P. appears more intellectually handicapped than this but the comparatively minor nature of her handicap is revealed in sensible conversation when she is encouraged not to be "childish". The occupational therapist reports a slight, but definite, recent increase in manual skill.

Miss N.I. has had a behaviour handicap since her early years, which shows itself in great lack of self-confidence and need for constant re-assurance, probably due to a broken home. This could explain her inconsistent use of her vision - she shows great interest and understanding of picture post cards, but does not use her vision in practical skills. The minus added to her score of (iv) for occupation is ascribed, by the therapist, to a loss of interest, which, I think, may well be due to N's pre-occupation with her desertion by her parents which is now complete. This is intensified by her realisation, often expressed, that all the other Condover ex-pupils either go home for holidays or have visits from relatives.

Miss M.T. is very seriously physically handicapped in all limbs, manual activities presenting severe difficulties. Fortunately, she has a pleasant voice, is interested in conversation, discussions, etc., and has a remarkably good verbal memory. In fact in the verbal aspects of intelligence testing she would rate (A) for intellectual handicap, rather than the (B) I have scored for her.

Miss E.R. is the most independently mobile of the eight ex-pupils though she would need supervision for journeys outside the Home. Her abilities in self-care appear to have decreased since she was at school. She enjoys performing simple tasks to aid the staff. E. needs residential care, but, in my opinion, if pressure on admission to the Home from more seriously handicapped people increases, she is the most likely to manage elsewhere. A good placement would be an A.T.C. for the Mentally Handicapped with an associated hostel.

Miss Q.Y. presents some unusual behaviour. Her vision has been diagnosed as "cerebral in origin". Since there are no defects observable in her eyes and there is no evidence of marked damage to the optic nerve it is assumed that the handicap is due to some defect in the visual mechanism in the brain. Q. considers that she is not blind, but there is no real evidence that she has visual acuity above the level of light perception. One of her present worries was revealed in a remark to me: "I haven't got too much sight to be allowed a talking book, have I?" Yet, in the past, she has been offered a talking book but refused it, although she is intelligent enough to enjoy some of the many recorded novels which are available through this valuable service. It seems to me that some of Q.'s other difficulties, such as uncertainties of balance which affect her walking, an irrational tendency to become worried by very slight difficulties and a hesitant and diffident expression of her thoughts could also be described as "cerebral in origin". It is interesting to note that Q. is the best of the ex-pupils as far as self-care is concerned.

Social Life and Leisure Time Interests

It has to be recognised that the ordinary chores of life take longer for seriously physically handicapped people. Multiple handicaps also naturally inhibit the length and variety of activities and can lead to fatigue. At least three people of the eight like to be in bed by 9.00 p.m.

In the Leisure Time section of the Personal Questionnaire, which was completed by all eight people, there was a three-fold choice introductory question concerning each individual's feelings about his present leisure activities. I acted as secretary to each person for the completion of the questionnaire and all eight replied that they were satisfied, rather than fairly satisfied or dissatisfied, with things as they are. I went to considerable trouble to make sure that the answer would be quite objective and that no one felt under the obligation to give an acceptable answer, rather than a really personal opinion. There are two sections of the questionnaire seeking information about leisure time activities inside and outside the Home.

Within the Home many communal facilities are provided. Television, radio and a stereo record player are available in different rooms to avoid interference. There are three sitting rooms, a small heated indoor therapy-swimming pool and an excellent occupational therapy room. There is much visiting by residents to each other's bed-sitting rooms which are spacious enough for small groups to listen together if they wish to their own radio, record-player, talking book or tape recorder. Some people have one of each of these pieces of apparatus and anyone who really wanted to acquire one would be able to do so either as a present or from his own savings. The manipulation of a record player and a tape recorder is difficult for some people but for one young man the use of the tape recorder is a very interesting hobby which he shares with two or three friends.

Only two people of the eight were ever able to make any progress with braille and only the more successful one of these two uses the medium effectively. He reads the "New Beacon" occasionally but his main use of braille is for correspondence.

Residents are not required to take part in the general chores or household duties of the Home — just one of the eight does a little voluntary helping.

A telephone is available for residents' use — a normal 'phone, not a coin box. Of the eight people, one young man — the tape recorder "addict" — uses the 'phone independently and frequently and could manage a coin box; two never use the 'phone, having no friends who are on this service; the other five make occasional use of it but need help with dialling.

Although the leisure time situation within the Home is varied and quite full, the leisure activities for the residents outside Wilberforce are few, as the following facts concerning the eight people under review demonstrate:

Swimming Three people learned to swim at Condover and have since been taken to public baths but this proved unsatisfactory due to inadequate changing accommodation and the low temperature of the water. The new swimming bath will solve this problem from the exercise point of view, but there seems little likelihood of anyone going swimming elsewhere.

Clubs, Choirs, Evening Classes, Study Courses There are no opportunities at present. Efforts are currently being made to link the residents with Local Authority's Further Education scheme with the hope that the less academic courses might prove attractive to at least some people.

Pubs Only one person — and he only very occasionlly — goes to a local pub. Two others go occasionally when they are at home on holiday.

Church One person attends a local church regularly and a second person is on the rota for occasional attendance at another church. All eight, according to their own choice, attend special services which are held regularly within the Home by three denominations.

Concerts and Theatres Attendance at these is almost completely confined to outings organised by the Home staff who also arrange occasional visits to the seaside and country and to a race meeting. The Home has its own purpose built 29-seater coach with hydraulic lift.

Special Interests One person of the Condover group has enjoyed for three years weekly sessions of horse riding organised by the Riding for the Disabled Association and has found these both enjoyable and physically beneficial. He also attends Scouting meetings.

Holidays Six of the eight people spend holidays at home going there two or three times per year for periods totalling from two to six weeks. The other two have no home to go to, but one receives frequent visits from her grandmother who takes her occasionally for a holiday in a hotel, etc. The other homeless person feels her position quite deeply but after taking one holiday provided by the Red Cross, now refuses to go again. The Red Cross offers a hotel holiday at the seaside and four of the eight people attend and thoroughly enjoy it.

A reasonably small amount of formal organisational procedure does not detract from the general atmosphere of a pleasant home-like situation for the residents, to which all members of staff, most of whom are non-resident, contribute through their cheerful, compassionate attitudes and essentially friendly contacts with the blind people.

Commentary and Suggestions

On a recent visit to Wilberforce, the Superintendent and his wife, who is Matron, asked me if I thought that they and the staff are giving too much help to the residents and are not expecting them to be independent enough. My considered reply to this question, and its extension to the topic of community help, forms the basis of the rest of this discussion. I shall consider Wilberforce and its 20 residents generally, not confining my remarks to Condover ex-pupils only. It is important to remember that, for most of the residents, placement at Wilberforce is likely to be for life. Only rarely are people admitted for a period of rehabilitation though I hope the Committee of the Home will count this as an important function of the Home, which should be continued.

For convenience of discussion I find it helpful to consider the 20 people in three sections according to their abilities and interests. Although in only one section is there any close group identification - and even this is incidental rather than formally planned - I will refer to the sections as Groups 1, 2, and 3.

Group 1. Among my descriptions of Condover ex-pupils and their activities, there was one well-occupied man who figures several times. He is the person with the tape-recording hobby with interests in horse riding and scouting, etc. Two friends - one is a Condover ex-pupil, too young to be included in my research survey, and the other was educated at a school for the blind - often join in his activities. All three are interested in national and local current affairs and in ideas generally. They form what, from lack of a more appropriate word, I call an academically-minded group, Group 1.

Group 2 is composed of a few middle-aged non-Condover people plus one or two Condover ex-pupils. There is no homogeneity about this group. They have quiet interests involving more adult thought and attitudes than the people in Group 3, but without the demonstrative, creative and enthusiastic tendencies of Group 1.

Group 3, again not a homogeneous group of people, is composed of younger residents, mainly young women, whose interests tend to be immature.

Independence of Residents

The very great variation in abilities and interests of the residents does not give rise to conflict since there is enough space within the Home for simultaneous activities to take place without causing any interference one with another. There are few changes which I can suggest for independent action by residents within the Home and it would be a pity to spoil the pleasant spirit

of independent choice which prevails. A Residents' Committee was set up some time ago to suggest or make public within the Home ideas for new activities, but it has had little success. The staff feel that the other residents are lacking in ideas. I put forward, with considerable diffidence, three suggestions of a practical nature to promote more independence in residents and less staff help. One concerns the development of a rota involving residents in household duties, since, at present, meals - even snacks - clearing up, etc., are provided as at a hotel rather than as at home. This, together with a scheme involving residents in improvements and/or activities in the Home's fairly extensive and flat grounds, could be two items for a staff-residents meeting. My third suggestion is that there could be a gradual drive, based on encouragement and short developmental steps and avoiding as much as possible undue frustration, towards improving standards of individual self-care.

Contacts with the "Outside World"

When I turn to the topics of activities for the residents outside the Home and visitors from "outside" coming to the Home, I feel on firmer ground in making suggestions. The staff arrange outings for the residents and this is a way of extending their experiences, but it still continues the isolating effect of a residential home for the handicapped. What is needed is a degree of integration for the residents into the life of the surrounding community. In spite of several attempts by the Wilberforce staff to enlist voluntary help for the residents, only a few positive responses have arisen. The Riding for the Disabled Association has given valuable and continuing help, which enables a few residents to be enjoyably occupied away from the Home. The Round Table has recently begun visiting the Home and accompanying residents to entertainments outside the Home. A certain amount of Church attendance takes place, supplementing the services which are held in the Home. So far there has been only a very little development of friendship at a personal level between residents and friends from outside.

Nearly everywhere there are individuals and organisations with the wish to help handicapped people and I am sure these people must exist in the neighbourhood of the Wilberforce Home. In this matter the staff of the Home have the important task of facilitating the initial contacts between residents and friends from outside and of providing continuing liaison. It is unlikely that voluntary help would reduce markedly the duties of the staff and that is certainly not the objective behind the exercise. Integration into the community will require as much effort by the staff as by voluntary helpers. There is no magic wand to be waved whereby integration automatically happens. Much ingenuity in planning and sustained efforts to maintain and improve any projects, plus considerable goodwill so that obstacles can be overcome, are necessary. Apart from any improvements for residents, there are likely to be benefits to the staff too, whose own sense of isolation in a very specialised task can be decreased with the growth of integration.

The Residents' Wishes and Interests

The interests, abilities and desires of the residents must be kept in mind. Some may, at first, have no real wish for contacts with outside people though one would hope that, with sensitive planning to suit individuals, this lack of desire might be changed. It will be helpful to consider the three groups whom I described earlier and I make the following tentative general suggestions:-

Group 3 would enjoy receiving occasional visitors at the Home and making visits to entertainments, not only professional shows, but the kind of concert, social and meeting which take place on a local basis. They could be expected to be, in the

main, passively interested only. Visitors might be surprised by the immaturity of the behaviour of some people in this group, but continuing occasional contacts could well have mutual benefits.

Group 1, on the other hand, have very active interests in the Home which they would share with visitors who might well find contacts with these young men stimulating. Improvement in the range and depth of these residents' activities could develop. The young men in this group can be described as "essentially educable" and they might welcome attendance at classes, clubs, etc.

Group 2 lie somewhere between the other two groups. They would welcome the opportunity for conversation. Some might well become interested but rather passive members of the kinds of meetings organised by churches. One woman might enjoy attendance at a Women's Institute or a Townswomen's Guild.

The "Handicap Barrier"

An important fact to be remembered is that the residents are quite severely handicapped and, to people unused to the appearance and effects of handicap, there is what might be termed the "handicap barrier" which has to be passed before normal human communication and relationships can be established. Nevertheless, we found at Condover that this handicap barrier can be overcome effectively quite quickly. For instance, for many years the Shropshire Community Service Volunteers have provided a simple but valuable service by taking people confined to a wheel chair for walks in the neighbourhood. For nearly 20 years the Adoption Society composed of railway employees have provided a living link between the school and the community. Its members attend several social events per year at the school and take the whole school for occasional outings. I have always felt that perhaps the Adoption Society's most valuable contribution is the fact that some members have formed friendships with individual children, the central event being having them at home for tea once per month. The beneficial effect of this friendly act was greater than could be expected from 3-4 hours contact once per month.

Some Practical Suggestions

Although there is no need to over-stress a person's handicaps it is unnecessary to avoid discussion of blindness or physical handicap. In fact, unemotional conversation on this topic can be an easy way through what I have called the "handicap barrier".

First overtures towards helping can lead to more ambitious visits or outings. Helpers need not feel guilty if visits have to be abandoned, especially if no suggestions or promises of continued service have been made.

There is the idea of "dropping in to see someone" at the Home. This need not be very time consuming, but can give great pleasure. It is as well to have some objective rather than an unplanned conversation which can be embarrassingly halting. Going for a short "walk" is simple, since the ground and pavements near Wilberforce are level, presenting no great difficulty to wheel-chair pushing; listening to a gramophone record could have mutual interest. A pleasant little event for a resident would be for two people to take him, or her, for a drink in a local pub.

A short car ride can be very enjoyable for someone who rarely has this opportunity, especially if it can be combined with something like a short shopping trip, a picnic, or "come round home for a coffee".

The staff are exploring the possibility of some residents attending the city's Further Education and Evening Class schemes. A member of such a class could offer friendship, or act as escort. There must also be voluntary organisations which could welcome one or two residents into their activities.

Transport of physically handicapped people presents problems, but difficulties can usually be easily solved. Wilberforce staff can give advice, and, if really necessary, help by using the Home's transport.

One further suggestion: What about founding a Friends of Wilberforce organisation?

Royal School for the Blind Leatherhead

When a new Principal took charge of the Royal School for the Blind at Leatherhead at the end of the 1940's, he wished to carry out improvements. At that time the School had already long ceased acting as a 'School' and there were instead some small sheltered workshop departments, with residence for the workers, and a large home for elderly blind people and a few additionally handicapped blind people. A very important improvement scheme introduced by the Principal was the extension of the residential facilities for the multi-handicapped blind, including young adults, together with the provision of simple work occupations for the residents. The Principal consulted the R.N.I.B. about the possibility of some Condover School leavers taking up residence at Leatherhead. An exchange of visits between the Principal of Leatherhead and Staff and Governors of Condover took place and this led to applications being made by some Local Authorities for Condover ex-pupils to be admitted to Leatherhead. At that time I thought that admission would be restricted to people who had no homes or where home conditions presented special difficulties. However, the pressure on Local Authorities to find accommodation for additionally handicapped blind people was so great that a number of people whose home situations were not acutely difficult were also admitted. Throughout my report I will refer to the establishment as the School since, in spite of its change of function, this is still its official title.

When I began my research in 1971, 32 former Condover pupils were among the 200 residents at Leatherhead and early in my research survey, my wife and I spent a week visiting them there. In planning the whole research I had decided that I would make informal direct contacts with former pupils themselves and not seek a more formal approach through welfare organisations, etc. However, at Leatherhead, with so many people in one place, some streamlining of my normal procedure was necessary. With an ex-pupil living at home I was usually able to combine a personal interview with visits to the parents and often also to the appropriate occupation centre. Sometimes I was also able to interview a Social Services Officer. Mainly through considerations of time and expense, I was unable to manage visits to most of the parents of the ex-pupils who are now at Leatherhead. It was very convenient to have 32 ex-pupils in the same place with the consequent economy in time and expense this involved and, in having three occupation centres, two for men and one for women, on the same 'campus'. Although I felt I did not need the reminder, I was asked, in carrying out my enquiries, not to act in any way which would unsettle residents or staff.

When the time came for me to make a second visit, two and a half years later, to bring my information up to date, I was faced with some difficulties and I could not spend much time at the School. My wife and I were unable to complete our information gathering. The only ill-effect of this curtailment is that I have

not as many facts about some of the women residents as I would have hoped for. However, I feel I have enough information to enable me to make a reasonably full report and I am grateful to those staff who gave me so much help.

In addition I submitted my original script to the Principal and I appreciate his help. He gave me further information and pointed out some errors of fact and I have amended the script accordingly.

Condover ex-Pupils at Leatherhead

During the period of my research survey, one ex-pupil died and another left Leatherhead and I have been unable to trace her present whereabouts. Table 6.II is therefore concerned with 30 ex-pupils.

Table 6.II Handicaps of Ex-pupils Resident at Leatherhead (N=30)

		Leatherhead	Comparable Group
Sex	M	21	18
	F	9	12
Vision	PS	7	7
	PB	10	10
	B	13	13
Intellectual Handicap	Nil	2	6
	A	20	12
	B	8	8
	C	0	4
Physical Handicap	Nil	26	21
	a	2	3
	b	2	3
	c	0	3
Behaviour Handicap	Nil	22	20
	m	7	6
	M	1	4
Deafness	Nil	27	26
	d	2	2
	D/B	1	2
Epilepsy	-	6	-
Promoted	-	3	-
Discharged	-	0	-
Occupation Estimate	i	2	-
	ii	9	-
	iii	16	-
	iv	3	-
	v	0	-

The last column of Table 6.II shows the distribution of handicaps for a representative group of 30 ex-pupils from the total research population of 314.

Comments

(1) It will be seen that the spread of visual handicaps among the Leatherhead people is identical with that of the representative Condover group.

(2) As far as intellectual handicaps the Leatherhead people are mainly of moderate severity (A) with a slight bias to severe Handicap (B). This was the range of intellectual handicap which was considered correct for Leatherhead when the young adults began to be admitted.

(3) Although, in the early days, I understood that people with physical and behaviour handicaps would be excluded, it is interesting to note that some people with these types of handicaps are now in residence.

Occupation for the Residents

Although I am concerned with the 30 Condover ex-pupils, I should point out that all the 200 residents take some part in the occupation scheme. There are three occupation departments, two for men and one for women and, in addition, there is the only surviving department from the former Sheltered Workshop, where some mat-making still takes place but where there is also much work similar to that of the two other departments. In all departments there is a certain amount of packing work but the women perform a considerable variety of simple craft-work.

In the men's department there is a well-developed minor industry based on the inspection and packing of wheel-balancing weights for cars. The lead wheel-weights arrive in huge quantities from the factory in the rough condition in which they leave the moulds, joined together in groups of four.

The staff have broken down the jobs into simple processes which include stripping the weights of the excess metal, inspection of the weights for defects, packing the weights in small packets of 50 or 100 which are then assembled in larger containers. There is need for a fair amount of movement of the weights from one section of the workshop to another which provides another activity. The whole process provides a number of simple occupations in which different minor skills are required with overall standards of speed and accuracy. Though some vision is useful for some processes, there are good opportunities for the occupation of blind people.

Payment for Work

The School has a system of awards for work and, indeed, for a few other activities also. For men the awards resemble a weekly pay scale which varies from 50p to £2.00. Output efficiency is an important factor in estimating each individual's position on the scale. Most women receive a weekly award though this is not on such an organised basis as the men's and the payment is not as high. A few women receive occasional awards.

Occupation of Condover ex-Pupils

Table 6.III. summarises considerable information about individuals. The initials are not the true initials of the people. Each person's combined visual and intellectual handicaps are indicated by his or her position in the rectangles; additional handicaps are shown after the initials; the figures refer to the pay awards.

Table 6.III Handicaps and Pay Awards Related to Individuals (N=30)

Intellectual Handicap	Visual Handicaps		
	PS	PB	B
Nil	Miss I.T.(m) 1.60		Miss J.U. 0.75
A	Mr. L.B.(m) 2.00 Mr. H.H.(a) 0.50 Mr. J.T. 2.00 Miss M.S.(M)D/B occ. Miss D.U. 1.00	Mr. H.F.(b)(m)E 0.75 Mr. E.Q. 0.75 Mr. N.Y. 2.00 Mr. Q.V. 1.50 Miss F.O.(a)(m) occ.	Mr. K.C. E 1.25 Mr. R.D. 2.00 Mr. E.E.(d) 0.50 Mr. N.F. E 0.50 Mr. R.R. 1.50 Mr. C.S. E 1.00 Mr. R.T.(m) 0.50 Mr. R.Y. 1.50 Miss N.O. 0.50 Miss K.H. occ.
B	Mr. S.T. 0.75	Mr. K.B.(m)E 1.25 Mr. N.I.(m)E 0.75 Mr. N.T. 1.50 Mr. S.Y.(d) 1.75 Miss D.N.(b) occ.	Mr. I.H. 0.50 Miss H.S. occ.

Comment

Throughout the whole research survey I have found that, in employment and occupation, blind ex-pupils are nearly always at a marked disadvantage compared with the P.S. and the P.B. I was pleasantly surprised to notice that, among the nine blind Condover men at Leatherhead, although four are paid at the minimum rate five receive £1 or more.

Suitability of Some People for Employment

Table 6.II showed the work/occupation estimates of the ex-Condover pupils at the time they left school. Two were rated as (i) and nine as (ii), i.e. they were thought to be capable of open or sheltered employment. The statistics for these eleven people, taken from Table 6.III are reproduced here as table 6.IV. where it will be seen that they are mainly among the highest paid on the award earning scheme. Among the four women are two of the only three who receive a weekly payment and among the seven men are the only four earning the maximum weekly amount of £2.00.

Table 6.IV Ex-pupils Once Thought to be Suitable for Employment (N=11)

Intellectual Handicap	Visual Handicaps		
	PS	PB	B
Nil	Miss I.T.(m) 1.60		Miss J.U. 0.75
A	Mr. L.B.(m) 2.00 Mr. J.T. 2.00	Mr. N.Y. 2.00 Miss F.O.(a)(m) occ.	Mr. K.C. E 1.25 Mr. R.D. 2.00 Mr. C.S. E 1.00 Miss N.O. 0.50
B		Mr. N.T. 1.50	

If the 11 people were really suitable for employment, one would not expect to find them at Leatherhead. Possible explanations of their presence there include lack of reality in the original estimates, unavailability of employment, priority of residential placement over employment, changed circumstances of individuals and

the lack of desire to change a comfortable life situation. I will give notes on the 11 people in the light of the above points.

Miss J.U. aged 42 and Mr. N.Y. aged 31 were both employed in the Sheltered Workshops when this facility was formerly provided at Leatherhead. J's health has deteriorated and it is very unlikely that, at her age, she could manage life and employment elsewhere. N. might well not qualify for admission to a sheltered workshop but I think he would be worth a trial.

Miss N.O., aged 30 and Mr. K.C., aged 31 and Mr. N.I., aged 30 all attended vocational assessment courses and were thought unsuitable for employment. Our work/occupation estimates were too optimistic. This may well be true for two other people who attended vocational assessment and were slightly more suitable for employment. Miss F.O., aged 32, ostensibly because of travel difficulties, turned down the offer of a trial in a sheltered workshop many years ago. Mr. R.D., aged 25 has had no work opportunity. His experience at Leatherhead has brought about an improvement and, although a trial in a sheltered workshop is indicated there might be difficulty about residential accommodation.

Mr. C.S., aged 36 failed a training course in a traditional trade and increasing epilepsy would make employment impossible. Although Mr. L.B., aged 29 has fairly good work potential from the practical point of view, his uncertainties of mood and behaviour, probably due to brain damage through a tumour operated upon in infancy, would make employment unlikely.

Miss I.T., aged 21 carries out some effective domestic work at the School and seems to have similar ability to another former pupil who is employed in domestic work in a hospital and lives in a staff hostel. Miss I.T. would be capable of similar employment. Mr. J.T., aged 34 is personally very independent and seems to me to be worth a trial in a sheltered workshop.

Thus it seems that, of the 11 people under discussion, only four are possibilities for employment. Successful placement in any case would be by no means certain and one has to ask whether it would be worth upsetting a reasonably satisfactory present situation. I had misgivings that the admission of a person at Leatherhead is likely to be a permanent placement, since no Condover ex-pupil has been promoted to a work situation. The Principal assures me, however, that individual cases are always under review.

Residential Facilities

The Condover ex-pupils are not a special group at Leatherhead but are integrated into the provisions for all residents. With one exception - that of a man who is paid for privately - the fees for all Condover ex-pupils are paid by Local Authorities under Part III Accommodation Regulations. The normal Social Security allowance to an individual is incorporated in the fee of £1,200 per annum (in 1974) from which each person receives a weekly pocket money allowance of £2.00. Any awards for work are additional to this allowance but must not exceed an extra £2.00 per week.

The living accommodation is in buildings which formed the original school and were completed in 1902. Each 'House' has an average of about 28 bedrooms in the form of single cubicles with sufficient space to provide a bed-sitting room. The cubicle walls do not reach to the very high ceilings of the large room which has been subdivided. The Houses have a large sitting room for the residents. Other rooms for leisure time use are available in the central building of the School. Washing and bathing take place in ablution areas in each house. All meals are taken in the one central dining room.

All houses have a married couple in charge. Domestic help is provided. To cover off-duty periods, it is necessary for house-parents to supervise two houses occasionally and they have some duties to perform in the main dining room. Most residents are independent in self-care but the house-parents are certainly kept very busy.

The school has large, very pleasant, park-like grounds well provided with roads which are a considerable help with the independent movement of blind people.

Mobility

My enquiry concerned with completely independent mobility covered all the ex-pupils in the research survey except those resident in hospitals. It was based on a simple list of statements starting from one which implies complete dependence: "I never go outside home alone." The stages which built up to what I considered to be 'complete independence' were neighbourhood walks, walks of at least two miles, use of local transport and, finally, use of long distance transport. Since walks of two miles in city surroundings can be unrealistic and since many people have no need to use long distance transport alone, I consider that a very effective level of independent mobility is neighbourhood walks plus use of local transport.

There are two special features which should be noted:

(a) The School has extensive grounds and with two exceptions — one very physically handicapped man and one man who suffers from frequent epilepsy — all ex-pupils have some independent mobility in the grounds. I shall therefore use the criterion "Never alone outside the grounds" instead of "outside home."

(b) A number of ex-pupils who never go outside the grounds alone, do go out with another resident, a few acting as guides for less mobile friends.

I give now a summary of the independent mobility of the 30 Condover ex-pupils.

(1) Five people are completely independent:- four men — two PS, one PB and one man who has only a very little sight and in my definition of visual handicap comes in the category 'blind'; one PB woman, though it should be noted that she is selective about the use of buses, because she has a minor physical handicap and finds the high steps of some local buses very awkward.

(2) Three PB men are in my category of effective mobility, using local transport and neighbourhood walks. I include a third man who never uses transport alone but will take another resident less mobile than himself on buses.

(3) Four people do not use public transport but manage long walks:- three PB men, one of whom takes the walks when on holiday or at home, but not at Leatherhead; one PS woman.

(4) Three people take neighbourhood walks only:- one PS man, one blind man and one blind woman.

(5) Twelve people never go alone outside the grounds:- seven blind men; five women — one PS, one PB, three blind.

(6) Three other people never go along outside the grounds but they have severe additional handicaps — one is deaf, one is severely physically handicapped and one has frequent epilepsy.

Comments

(1) Of the 12 people in paragraph five, 10 while at school had gained, after training, the privilege of independent mobility in the village. Three were having mobility training in Shrewsbury.

(2) With one exception — a woman who, as an adolescent spent less than one year at Condover in 1948 — all the people in paragraphs 3 and 4 were granted independent mobility in the village.

(3) No training in the use of transport was given at Condover, but, with two exceptions, all the people in paragraphs 1 and 2 were having training in Shrewsbury. The exceptions — one man in paragraph 1 and one man in paragraph 2 — have made very good progress since leaving school.

(4) It is urgent that Condover ex-pupils, especially those who are blind, should make more use of the training available from the School's mobility officer and the visiting mobility officer from Surrey Social Services.

Leisure Activities

One important part of the personal questionnaire which I issued to all ex-pupils who are the subjects of my research survey, except those in hospitals, was an enquiry concerning the use of leisure time. Ex-pupils living at home were helped usually by their parents in the completion of the questionnaire. For the ex-pupils at Leatherhead my wife and I gave this secretarial help acting in accordance with the suggestion I made at the beginning of the questionnaire: "I realise that you will need some help in filling the papers in, but I hope you will give the answers yourself to as many of the questions as possible."

An introductory section was of a general nature, the subjects being asked to choose which of three statements fitted their leisure situations best, with the following results:-

(1) Eighteen are satisfied with things as they are.

(2) Nine are fairly satisfied, but would like a few more things to do.

(3) Three are often bored and would like to do a lot more in their spare time.

Activities at "Home"

In the "at home" part some questions dealt with literacy, others dealt with listening in various forms: radio, records, etc., and there was one question each about use of the telephone and help in household chores. In addition an opportunity was given for the description of any individual's special interests not included in the questions.

(a) Literacy

Nineteen ex-pupils do no reading or writing.

Three people are braille readers, i.e. in the year preceding completion of the questionnaires they had read at least five library books. All three write occasional letters in braille.

Six people do some occasional braille reading:- one person reads the "Torch" magazine; another reads the magazine "Trent" and knitting patterns: two people read sports fixtures; one reads the Radio Times and braille announcements; the sixth reads the Prayer Book in connection with church services and the Institution's choir. Only two do any braille writing — occasional letters.

Three people do some sighted reading:- one person reads the large print edition of the "Torch" magazine; one person, who does some braille reading, also

reads large print occasionally; the third person reads public notices only. The first two write occasional letters.

Comments

(1) Only three of the people who do no reading or writing made any progress in literacy at school, and this was only at an elementary level.

(2) Some Condover ex-pupils should attend the typewriting lessons which are available at the school.

(b) Listening

Twenty-seven people listen to radio every day, or nearly so. Of the three who say they only listen occasionally, two have hearing difficulties. Although much of the listening is rather indiscriminate, 16 people expressed interest in news and associated commentaries; 10 people follow serials, including seven devotees of the Archer Family. Most people are "pop" fans but seven have other music listening interests.

Eleven people never use television. Eight use it most days, including three blind people; two or three use it two or three days per week; eight listen or watch occasionally.

Listening to gramophone records is very popular and there is considerable knowledge of groups, singers, popularity charts etc. All 30 ex-pupils listen to records at some time:- 15 occasionally, eight two or three days per week and seven most days.

There is some interest in tape recording, but this implies the ownership of a personal recorder and skill in its management. For four people the tape recorder is frequently used and is a hobby. Four other people use a recorder occasionally. Twenty-two make no use of the apparatus.

Very little use is made of the Talking Book. One person "reads" most days; another reads two or three days per week; seven use the apparatus occasionally.

(c) Household Chores

As the life of the institution is organised, there is little opportunity for residents to help in these matters. Five give occasional help. Eleven other people help at home during holidays.

(d) Telephone

Two people use a coin box independently; three use the operator; eight seek help from friends; three answer incoming calls only; fourteen people never use the 'phone.

Comments

Some Condover ex-pupils should apply for training in the use of the telephone which is provided by the School.

Activities away from "Home"

Six questions required the selection of one of three possible alternatives:- "I do go", or "I don't go but would like to", or "I don't want to go".

(i) Swimming: One person goes swimming quite independently; nine do not go swimming but would like to do so (eight can swim already); five only go swimming when they are at home and would presumably like to go while in residence at Leatherhead; 15 have no wish to go swimming. However, a swimming bath is to be opened in the town shortly and arrangements will be made for the residents to attend if they wish.

(ii) Attendance at Clubs: All the clubs used, apart from one, are for handicapped people. The exception is a Church Youth Club in the town where a Condover ex-pupil goes as a helper. The clubs for the handicapped meet either fortnightly or monthly. Twenty ex-pupils attend one or other of five available clubs, 16 going to the one which is most easily accessible. A few people attend two or three clubs. The activities of all clubs are of a social and entertainment nature, except the Torch club which is a religious organisation. One ex-pupil attends a club for the handicapped at Hammersmith.

(iii) Attendance at Pubs: This is permitted by the 'School' but residents are expected to return home by 10.00 p.m. in a sober condition. Three people visit a pub two or three days per week, five go once per week and nine go occasionally. Three people who do not go would like to do so. Ten people have no desire to go to a pub.

(iv) Dancing: This can hardly be considered as an "away from home" activity since the 'School' organises internal dancing sessions. Twenty ex-pupils attend the dances and 10 do not wish to do so. Two ex-pupils go to dances outside: one man goes to occasional public dances and a woman attends dances organised by the church which she visits on Sundays.

(v) Churchgoing: This also is hardly an "away from home" activity since the 'School' has its own church with a choir recruited from the residents. Twenty-three ex-pupils attend this church every Sunday morning, five go to church occasionally while two do not attend. Two ex-pupils are also regular attenders at churches in the town and three others attend churches in the town occasionally.

(vi) Concert/Theatre Visits: These are organised by the 'School', though residents contribute towards the costs. Outings take place about 12 times per year. Nineteen ex-pupils go on these outings, one who does not go would like to do so, 10 have no desire to go.

I also report that:-

seven men and four women are members of the internal Church choir;
six men are members of a male voice choir organised by a member of the staff;
one man goes to an evening class run by the local education authority;
one woman expressed a wish to attend evening classes;
one woman attends a study group at the church which she attends.

Other Activities not Covered by Answers to the Questionnaire

As far as activities "at home" are concerned individual special interests which were mentioned were piano and organ lessons, recorder playing, self-taught guitar playing, caring for large collection of pot plants, tape recording as a hobby, study of the weather and making scrap-books for the interest of handicapped children.

Several very interesting "away from home" activities were mentioned: one man travels widely, using buses and trains, in South-East England; one man has long been a keen supporter of Leatherhead Town Football Club, attending most home matches and some away matches, and he now takes a younger man to matches; another man attends occasional concerts at Fairfield Hall, Croydon; the woman with church interests in youth club and study group activities is also a member of the Townswomen's Guild.

Comment

The School now has a senior member of staff whose duties include co-ordination and extension of leisure activities, which should lead to improvements.

Holidays at Home

The usual pattern for holidays at home is for a fortnight at both Christmas and Easter and five weeks in the summer. Residents come from many parts of the country. Travel and subsistence allowances are made for the holiday periods.

Twenty ex-pupils spend these holidays with their parents and four with other relatives. One spends occasional week-ends with relatives. Two have no parents or interested relatives, three have lost contact with their parents. The School organises summer holidays for residents who have no holidays at home.

Six people who take the full holidays also go home for half-term breaks, while two people who live fairly near to the school pass some week-ends at home too.

General Summary and Commentary

During the past 20 years the Royal School has made a very important contribution to the welfare of additionally handicapped blind adults. I wonder if the School should be known as a Community rather than a School?

Parts of the institutional type buildings erected at the beginning of this century, with the very large rooms which were then fashionable, have been modified to make much more pleasant living conditions for the residents. Because of the massive scale of the construction of the School it seems unlikely that further domestication of the living arrangements will be possible and that the present centralised cooking and dining arrangements for the 200 residents plus staff will have to continue. Although I am in favour, in principle, of the erection of fairly small residential units with independent domestic arrangements with which residents can help, I cannot see how this facility could be developed at Leatherhead. It is possible, however, that the School's administrative and residential staff might be more optimistic about changes in this direction.

The School's administration has developed for the residents a satisfactory solution of the balance between the regulations which are necessary in a large community of handicapped people and the personal freedom of individuals. The only reservation I have in making this statement is that perhaps more help could be given to some of the less mobile residents who might like to gain some of the independence attained by the more able.

Another problem of balance concerns the segregated activities of any residential establishment in relation to integrated activities involving the neighbouring community. This is particularly important with social life and it varies among the individuals who comprise the residential establishment. It seems

to me - but the Principal assures me I am wrong - that Leatherhead town organisations do not provide as much help and service to the School generally and to individual residents in particular as might have been expected. Perhaps it is unreasonable to hope for increased help from a town of Leatherhead's size, especially as there is another large establishment for the handicapped in the neighbourhood. I point out that the Principal considers that my criticism is unjust.

There are some more detailed matters on which I put forward, with some diffidence, some tentative suggestions for consideration rather than positive recommendations. My diffidence is partly due to the fact that some of the suggestions imply employment of extra staff which is not only a costly affair, but staff are difficult to find anyway. It is possible, however, that some items could be considered to be services with which the local Social Services Department and Education Authority could be expected to help.

1. It appears that there is a need for an extension of mobility training in two associated directions:-

(a) for the improved personal independence of individuals in walking and in use of public transport, and

(b) the analysis of the traffic problems in the neighbourhood as far as visually handicapped people are concerned with the consequent development of formal mobility routes in the town. I was pleased to hear that the local Accident Prevention Officer has this matter in hand.

2. At Condover the staff felt that some pupils, at school leaving age, had reached the stage of being able to profit from more education which might have remedied some of their lack of progress. This opinion has been confirmed in my mind when, in the course of my research, I have met a considerable number of ex-pupils who have matured more than I had expected. This is certainly true for some ex-pupils at Leatherhead. A special programme of "Further Education" would probably be beneficial. Subjects could include:-

Remedial reading and writing, i.e. a chance to try again.
Practical living, including management of money, use of telephone, simple homecraft, social and personal skills.
Current Affairs.
Dramatics, including tape-recording.
Typewriting classes for the literate residents.

3. Would it be possible to establish some form of "Friends of the Royal School" organisation?

4. Some forms of involvement of residents with responsibility for certain aspects of their life might be very useful, e.g. house meetings in which day-to-day business projects for improvement, planning of events and the running of clubs could be on the agenda.

Greenside, Christopher Grange

In 1972 the Catholic Blind Institute at Liverpool opened Christopher Grange, its new Centre for Adult Blind. As well as providing a Day Centre and residential accommodation for elderly blind women, the Institute has opened an annexe "Greenside" which offers residence for 14 multi-handicapped visually handicapped young women.

Greenside, which is one of the entirely new ventures recommended by the Vernon report, provides a programme of assessment, further education and social training, with no occupation centre, though Christopher Grange has a Day Centre for the Blind and the Physically Handicapped.

Greenside is definitely what I think of as a domestic sized and organised unit. There are two single bedrooms and six double bedrooms. A lounge with an alcove, a tuition room and a "quiet room" provide a variety of leisure rooms. All meals are prepared and eaten in the Unit. The residents are encouraged to take an active part in the running of their home.

Three Condover ex-pupils aged 21, 22, and 23, attend Greenside. They are considerably more seriously intellectually handicapped than the other young women who are better described as 'retarded' rather than multi-handicapped and who are, in effect, undergoing a lengthy period of rehabilitation or remedial education. I will give notes on each of the three ex-pupils.

Both Miss T.M. and Miss K.U. are blind and have intellectual handicap (B). Both have epilepsy, T.'s being of a minor nature, but K. has occasional severe attacks. They are unable to profit from the academic sections of Greenside's education programme though they take some part in its practical activities. They are fully involved in household duties, social education and leisure activities. If the Centre for the Blind and Physically Handicapped had an occupation section for the mentally handicapped, these two young ladies would have an admirable programme.

Miss B.I. is non-resident and lives with her widowed father. It was difficult to decide in which section of my research to include this blind young woman, so, although she is non-resident and has consistently refused offers of coming into residence, I am dealing with her in this chpater. B. is more capable than Misses T.M. and K.U., having an intellectual handicap (A) and she has more practical ability than the other two young women. B. says she does a good deal of housework at home — sweeping, washing up and bed making. There is a likelihood that she will be admitted to an A.T.C. near her home. Under the circumstances this may well be a better placement for her, though her stay at Greenside has been a helpful holding operation for Miss B.I.

Comments

(1) At Greenside the two fairly seriously multi-handicapped ex-pupils find the sheltered existence which they need, with sufficient stimulation to prevent any lapse into inactivity and boredom.

(2) Although the Catholic Blind Institute has no further plans at present, its Committee remains interested in possible future developments for the multi-handicapped.

SECTION B Ex-pupils in Residential Establishments Without Special Provision for the Visually Handicapped

Eleven ex-pupils, each in a different establishment, are resident in places of this type. There are considerable variations in the establishments:-

Five are provided by Local Authorities, three for physically handicapped people excluding the elderly, one for elderly people with an annexe for younger handicapped adults and one for homeless and inadequate men. Three are provided by the Spastics Society. One is provided by each of the following organisations:- an Epileptic Colony, a Cheshire Home, and the British Red Cross. Most of the 11 establishments have associated occupation centres, but in the cases of all 11 ex-pupils their primary need was for residential placement.

Table 6.V Personal Statistics. People in 'Non-specialised' Residence (N=11)

	Age	Handicaps						Occupation Estimate
		Visual	Int.	Phys.	Beh.	Deafness	Epilepsy	
Mr. E.R.	29	PS	A	Nil	m	Nil		ii
Mr. L.A.	39	PB	A	Nil	Nil	Nil	-	ii
Miss K.G.	39	PB	A	b	Nil	Nil		iii
Mr. C.B.	23	B	Nil	b	Nil	Nil	-	iii
Mr. N.C.	24	B	Nil	c	Nil	Nil		v
Mr. S.D.	25	B	Nil	Nil	m	d	-	v
Miss K.N.	31	B	Nil	a	m	Nil	-	iii
Mr. G.E.	25	B	A	c	Nil	Nil	-	iii
Miss B.H.	25	B	A	b	Nil	Nil	-	ii
Miss Q.O.	28	B	B	b	m	Nil	-	iii
Mr. H.F.	24	B	C	c	Nil	Nil	-	v

I will give some notes on each person, ending each case description with my personal opinion about the suitability of the present position.

Mr. E.R. has a long history of epilepsy which is now fairly well controlled since he now suffers only occasional periods of confusion and alteration of consciousness which last two to three minutes and which occur monthly at a frequency which can vary from none to about eight. When I met E. early in my research survey he was living alone in the house in which he had lived with his mother until she died about a year previously. He was managing fairly well with occasional supervision by Social Services and his own sister with much help from a kindly neighbour. Helpful factors also were E.'s useful vision, his independence in self-care and his desire to manage and to keep his rented house. Nevertheless I was considerably worried by the situation.

Since then he has been assessed in a Therapeutic Work Centre of the National Society for Epileptics. Fortunately E. made an independent decision that he would like to become resident in a hostel run by the Society and he has now given up his house. I have not visited Mr. E.R. at his hostel but I have received much useful information from the Society's personnel Staff and the young man has completed a personal questionnaire. He attends the Work Centre daily. He states that he is fairly satisfied with his leisure time. He is illiterate and he never watches television or listens to radio — an example of a certain fixity of ideas and actions which he showed as a boy. His chief interests are playing gramophone records, and carrying out household chores, which he does well. The residents have much freedom of movement outside the hostel and he joins friends for walks, shopping, etc., but he is personally independent in long walks and the use of local transport. Summary: a very suitable placement.

Mr. L.A. is a resident in a Home which is a pioneering venture in the care and rehabilitation of inadequate men: vagrants, drop-outs, etc., many of whom are elderly. Mr. L.A. is certainly not inadequate but this home was the only facility available when his need for residential placement arose several years ago. The staff of the home have helped L. to maintain his spirit of independence. He has his own bed-sitting room which he has helped to furnish himself. The Home is in a seaside resort where he finds summer-time employment in the kitchens of restaurants. He took my wife and me to lunch in the restaurant in which he was working at the time of our visit and then showed us the sights of the town including his favourite pub. Mr. L.A. uses his deficient vision very well. He is less than five feet tall which is an occupational handicap. When not employed, the staff of the Home have helped L. establish a minor business of basket making and stool seating. Summary: the present situation seems reasonably satisfactory but I wonder whether, with his strengths of personality and practical ability, he

could be helped to achieve greater independence, e.g. to live in a small flat or to find employment in some residential establishment.

Miss K.G. lives in a home for physically handicapped women which is administered by the British Red Cross. She is very much a part of the home, attending its occupation centre daily and taking part in organised outings. K. made the visit of my wife and myself a very pleasant event. She is well satisfied with her leisure-time activities in which braille reading and writing, a talking book and knitting are all very important. She shares a bedroom with three other women and seems to have no desire for the privacy of a single room. Since she has been in residential care since babyhood, sleeping in a single room is something she has never experienced. Summary: a happy, helpful person by temperament, Miss K.G. is very suitably placed.

Mr. C.B. is blind and fairly seriously affected by spasticity in all four limbs. He is of normal intelligence and, naturally, wanted to work. After a period of training in which he failed, and the non-appearance of any job which he could possibly manage, he has accepted the situation philosophically. The life which he leads in the Local Authority Home for Handicapped Young Adults has helped. At the time of our visit C. was sharing a bedroom with another resident but he has now been "promoted" to a single room which he much appreciates. He goes to the home's occupation centre "when I have nothing better to do". He is well satisfied with his leisure activities. Because of his physical handicaps he has been unable to learn to use braille, but he is a very frequent user of a talking book. He has taken a specially devised examination and is a Radio Amateur. He makes much use of a tape-recorder. There is some participation of residents in the organisation of the home, which accommodates 38 men and women. A Residents' Committee is able to make suggestions, discuss the general running of the place, etc., with the Warden and its staff. C. is very well aware of the advantages of this democratic approach. He tells me that certain officials of the Local Authority who are planning a second home for Young Handicapped Adults, consulted the residents about suggestions about the internal functioning of the new home. Until a recent illness caused C. to be confined to a wheel chair — hopefully just a temporary interlude — C. was mobile around the home using a stick. He needs help for journeys outside the home, which he readily receives, including visits to fortnightly meetings of the Local Radio Club. Summary: Mr. C.B. is the only blind resident but feels fully integrated into the life of the home. His placement is eminently successful.

Mr. N.C., who is blind and even more physically handicapped than Mr. C.B., lives in a Cheshire Home. He is very dependent, requiring help even with some simple self-care activities and he is confined to a wheel chair. N. is very aware of this need for help — he cannot even manipulate his own tape recorder. I think that he is fundamentally resentful of his condition and is unable fully to accept his situation. This is completely understandable, but has led to an attitude of complaint about the services he receives, tempered by the realisation that "they", the staff, are so busy. He uses the talking book a great deal. He is getting some help with the study of English Literature, Music and History but has no examinations in mind. A voluntary organisation which organises summer holidays includes N. in its arrangements to his great delight. Summary: what a problem! There is no vacancy at Wilberforce Home. If there were, perhaps this would be a better placement for Mr. N.C.

Mr. S.D. is blind, has no physical handicaps, but, from a very young age, had behaviour difficulties. His greatest success at school was learning to read braille but other progress, educational and social, was hampered by his behaviour handicap which was rated as (M). At leaving school his placement posed great problems since his parents had never been able to cope with him. S.'s grandmother

who gave him considerable support had died. Eventually he was admitted as a temporary measure to the Wilberforce Home where I met him several times. S. settled in there quite well and his behaviour handicap had decreased enough to be ranked as (m). He had to be withdrawn from Wilberforce so that physically handicapped blind people could be admitted. His next placement led to deterioration in his behaviour which became a severe problem. Fortunately, however, the opening of a new Home for Handicapped Young Adults by his own Local Authority, to which he was admitted, and where I have visited him, has helped considerably. As far as S.'s blindness is concerned, the staff of the home were aided in his settling-in period by a specialist Social Worker for the Blind who helped with some mobility training and ensured that S. had those benefits to which blind people are entitled. This included membership of the Braille Library and the loan of a talking book. He makes good use of these two facilities and joins in the home's general activities including educational and social outings. He makes little use of the home's occupation centre because he cannot manage the crafts which are the main basis of work there, but he attends two other centres in the town, one specialising with visually handicapped people. The staff have accepted S. with all his oddities of behaviour very well — he has bursts of loud conversation probably because of his slight deafness, occasional obstinacies and irrational conversational obsessions. This acceptance has helped to reduce his behaviour handicaps which can now be rated as (m) again. Summary: I understand that S.'s placement can be considered to be permanent which is a very satisfactory solution for Mr. S.D. By a strange coincidence the Home is within a mile or so of S.'s father's home (his mother has died), and S. now receives occasional visits from relatives. Incidentally, he considers that his present Home is "as good as Wilberforce" which, coming from S., is high praise for both organisations.

Miss K.N. is blind. Her physical handicaps, which were due to tubercular meningitis, are less than when she came to school shortly after the illness, and they can be now rated as (a). I suspect that her strange compulsive behaviour anomalies at school, which included "stealing" all sorts of things and storing them in obvious places, and damaging braille dots in books so that they became unreadable, may also have been sequels to the meningitis. She had and has, a very attractive side of her character which included a surprised, half-humorous awareness of her inability to stop such obvious misdemeanours. K. is now resident in a Home for Physically Handicapped People, where I have visited her. Some of the residents have jobs in the city, others attend the Home's occupation centre. K. is not really employable and she doesn't wish to attend the occupation centre. She has, however, a semi-official position as messenger and shopper for staff and residents. This occupies a considerable amount of time and improves her walking mobility in the neighbourhood though she does not use public transport. The shopping involves considerable responsibility and honesty and, whether this was a deliberate policy or happened by accident, it appears to have helped to solve K.'s "kleptomania" problem. Some years ago this became a very serious problem, for other residents who missed money and various articles became very annoyed with K. even if the missing articles were fairly quickly recovered. Fortunately this problem appears to have disappeared.

K. is satisfied with her leisure-time activities. She has a long list of favourite radio programmes, does some braille reading — an occasional library book and some magazines — and writes a few letters. Most days she helps with household duties mainly with table laying, which gives her contacts with daily staff which she enjoys. K. is a keen swimmer and is able to attend the Home's frequent swimming sessions. She attends Church twice every Sunday. Although she does not go home for holidays, K. receives fairly frequent visits from her mother. Summary: a very satisfactory placement.

Mr. G.E. has a very serious physical handicap being almost completely confined to a wheel chair and needing considerable help with self-care. By temperament, G. is placid and uncomplaining. He is resident in a special wing for ten younger (i.e. approximately 20-40 years of age) handicapped people, which is part of a much larger home for the elderly. I have visited G. in the home and appreciated the pleasant living conditions which include his own well-furnished bed-sitting room. He goes out to a centre for the blind one day per week but otherwise has long periods of inactivity. Although G. states in his questionnaire, completed for him by the Home Superintendent, that he is satisfied with his leisure time, his activities comprise only radio listening every day, occasional listening to records and very occasional (every few weeks!) visits to a pub. His parents are dead and visits from his brothers and sisters are very infrequent. At school he usually needed urging into activity and he became independent, or nearly so in self-care, while for occupation estimate he was considered to be of category (iii). Summary: G. is urgently in need of more activity, physical and mental. Unfortunately there are no vacancies at Wilberforce Home otherwise he would be better placed there. I understand that G.'s Local Authority are loath to send their handicapped people outside their area and would prefer to develop their own services.

Miss B.H. attends a Work Centre and is resident in its associated hostel, both organised by the Spastics Society. Although I have been unable to visit these facilities I have had helpful, pleasant telephone contacts with the staff and have visited B. at her home during a holiday period. I know she considers that she has achieved a considerable degree of personal freedom through her attendance at the Centre and Hostel. She claims that the residents have persuaded the staff that they should be treated as adults and not as children. B. attends the work centre daily where craft articles are produced by group effort, utilising methods which break down production into simple processes. She earns 75p per week. She is satisfied with her leisure time, which certainly seems quite full. B. reads six or seven braille library books per year and writes occasional letters. She "watches" television most days and uses radio, record player and tape recorder occasionally. Hostel residents carry out household chores according to a rota and B. lays the tables and helps with washing up one day per week. She attends club meetings once per week and goes occasionally to pubs with other residents. She feels that she is completely integrated into the life of both centre and hostel. She has recently become engaged to a member of the hostel. Summary: a successful placement.

Miss Q.O. is definitely very multi-handicapped with intellectual handicap (B) and behaviour handicap (m) additional to her blindness and physical handicap (b). When her mother could no longer cope with her daughter at home, Q. was found a place in a Residential Centre organised by the Spastics Society. The centre is in a large country mansion which does not lend itself to easy domestication but considerable modifications have taken place, though the building is not easy for a blind person. Unfortunately Q.'s multiple handicaps do not allow her to appreciate reality and when we visited her she was full of grumbles — as she tended to be at school. She shares a bedroom with five other women, but she had no complaints about this. She attends the work centre daily, and although she is on the lowest rung of the pay scale, she does receive £1.00 per week and appears to enjoy the centre. In leisure time she listens to radio and pop records most days. She says she would like to join the Braille Library, but she barely knows the braille alphabet. She claims that she does not go on outings, but the staff assure me that Q. takes full part in trips to the seaside, beauty spots, a zoo, etc. I realise that what I am writing may be conveying my feeling of exasperation. Poor Q., she must cause this reaction from so many people. In the last year she spent two separate weeks at her parents' home but did not want to participate in the centre's summer holiday. Summary: no other placement is

available. If a full range of residential facilities were available it is doubtful if a placement for Q. could be found more suitable than the present one. Perhaps the Spastics Society will replace the old mansion with purpose-built accommodation.....?

Mr. H.F. is very seriously handicapped indeed. He needs complete care and is almost completely unaware of his surroundings. He has very little communication and, apart from the care he passively accepts, he cannot profit from any of the centre's activities. H. was discharged from Condover as ineducable and I thought he might well need hospital care. Summary: I am surprised that H. has not been admitted to a hospital for the severely mentally handicapped.

Mobility and Literacy

To continue the information on these two topics which I am accumulating throughout the chapters, I record these facts about the 11 people in this section:-

Mobility:- two people manage long walks and use of local transport; one person takes neighbourhood walks; the other eight have no independent mobility outside home, which is due to their handicap.

Literacy:- three are braille readers; one makes some use of braille; the others are illiterate. Four people are keen users of the talking book.

Comments

(1) Mr. H.F. should be in hospital, liberating a place in his hostel for a more suitable person.

(2) Messrs N.C. and G.E. are only fairly satisfactorily situated, but no alternative placements are available.

(3) The other eight people are very well placed and I am sure that all, except Miss Q.O., would agree with me about this.

(4) It is important to note that six of the eight people of Comment (3) are blind and are well accepted by staff of hostels without special training or experience with blind people.

Brief General Commentary

This chapter has been concerned with 52 ex-pupils for whom residential placement was more important than occupation, though some, if a day centre had been available at the time of their going into residence, might not have left home. It should be noted that only a few of the residents have no parents and that most people make visits to their parental home.

The complicated question of domicile for ex-pupils and for handicapped adults generally is discussed in a special section of Chapter 9.

With reference to the present chapter I draw attention to the facts that interim summaries have been made throughout and that some suggestions concerning aspects of residential care were made at the end of the fairly lengthy descriptions of Wilberforce and Leatherhead. It seems, therefore, that a more detailed summary and commentary is not needed here.

CHAPTER 7

AT HOME WITH LITTLE OR NO OCCUPATION

Review of Contents of Chapter

After a brief general discussion, facts are given concerning the handicaps of the 66 people being dealt with in this chapter, summed up in Table 7.I.

Case descriptions are given of eight people who do not live in the parental home, as examples of what can happen when people cannot, or do not wish to live with their parents.

Table 7.II relates handicaps to individual people and also indicates those ex-pupils who are content with the present situation and those who would like more occupation. This complicated table is broken down into four further tables, arranged according to visual and intellectual handicaps, and giving personal statistics and including estimates of parents' opinion of the occupation situation. Case descriptions which follow are grouped to show my opinion of the suitability of each ex-pupil's situation. This section of the chapter ends with a brief summary.

A second part of the chapter, entitled Leisure Occupations, widens this concept to include aspects of independent living.

A short section discusses the Mobility and Literacy of the 66 people discussed in the present chapter and is followed by information concerning the leisure time activities of two groups of ex-pupils. These groups are the people discussed in this chapter, who have little or no occupation, and those dealt with in Chapter 5, who attend Day Centres, the information having been compiled from ex-pupils' personal questionnaires.

Information concerning ex-pupils' use of money and their independence in self-care, gained from parents' questionnaires, leads to a discussion of the general topic of independence/dependence and a five-point scale for estimating this. I give my estimates of ex-pupils' potential for independence and of their present performance.

Statistics are given about parents' opinions on the need for ex-pupils to live away from home now, and about arrangements as to what might happen when parents can no longer cope with ex-pupils at home. A brief commentary concludes the chapter.

Ex-pupils at Home with Little or No Occupation

Many people knowing something of Condover Hall School and its children have, throughout the years, posed the vital question:- "What do the children do when they leave school?". During the 1950's the answer had to be vague with an air of disappointment about it. Since the question was often put to me after I had shown visitors something of the work of the school, or at the end of a talk in which I had described the school's aims and practices, I will state the answer I gave during the first ten years of the school's existence. "A few fortunate, more able and less seriously handicapped pupils will, either during their school life or at the end of it, profit from the facilities which are available for 'normal' blind adolescents and adults. If I am pressed to give a figure for this fortunate few, I would estimate that about 15% of all leavers will find employment in open or in sheltered conditions. On the other hand, I think there is an

approximately similar proportion of pupils who will, either during their school life or at the end of it, need permanent hospital care, most of them in hospitals for the mentally handicapped. With regard to the remaining 70% of school leavers between the two extremes of the workers and the hospitalised, most of these will return to their parents' home. We hope that the life of Condover will have helped these boys and girls to fit in better to their life at home, that they will have become more socially acceptable, more skilled in self-care, and more able to help with simple household chores."

If pressed further on the subject of occupation and activities outside the family, a matter often raised by parents, I had to conclude rather lamely:- "Most of the leavers will be able to attend occasional craft classes and social events arranged for blind adults — mainly the elderly — but I have no real hopes that more continuous occupation will be available."

Fortunately, since the end of the 1950's there have been considerable improvements in this situation. Although arrangements are still far from ideal, if I now had to describe the possibilities available for Condover school leavers I could justifiably be much more optimistic. Earlier chapters have described provisions which have been developed since about 1960 for severely handicapped adults. Although many of these facilities are not specifically for blind pupils, ex-Condover pupils and other multi-handicapped blind people have not been excluded from the provisions which have now been made available for mentally handicapped people and for physically handicapped people.

The Present Situation

It seems appropriate that I should deal last in my series of chapters concerning the present placement of ex-Condover pupils, with those whom I have found to be still in the category of "at home with little or no occupation". If there had been no improvements in the facilities since the 1950's, and using my estimated proportion of 70%, the gross number of people I would have expected to find largely unoccupied would have been about 220. The fact that the actual number now is only 66 is an indication of the remarkable improvements which have been made in the provision of simple occupation for seriously handicapped adults of all types since 1960 together with some increase in residential facilities. I must emphasise that blind people only account for about 3% of the population of the centres for the handicapped which have been developed in this short period of time.

Let us look in some detail at the group of "unoccupied" ex-Condover pupils all of whom, except three, I have visited. (I have had several long telephone conversations with one of the missing people and some correspondence about the other two.) As I develop my account of these people we shall find the number for whom the lack of occupation is distressing is comparatively small. My title for this chapter "At Home with Little or No Occupation" is somewhat misleading since it seems to imply that all 66 people are at home, idle, bored, etc., whereas this is certainly not true for all of them. Some have found a very pleasant way of life which they would not wish to change and six have found simple part-time jobs for which they receive a little payment.

I should make it clear that any handicapped person, who is not resident in hospital or is not able to succeed in open or sheltered employment, is entitled to a basic Social Security allowance. Blind people who are unemployed and permanently placed at home are allowed certain small additions above the basic rate. From July 1974 unmarried blind people receive £11.65 per week and are permitted to earn up to £2.00 per week without any deduction being made from the

Social Security allowance. The total maximum weekly income can be £13.65, which is a little less than half the wages received by blind people working in a sheltered workshop. Most of the people with whom I am dealing in this chapter do not earn any money.

Table 7.I At Home with Little or No Occupation. N=66

		Total (314)	Average Sample (66)	At Home (66)
Sex	M	190	40	31
	F	124	26	35
Vision	PS	75	16	11
	PB	102	21	21
	B	137	29	34
Intellectual Handicap	Nil	61	13	20
	A	129	27	24
	B	82	17	20
	C	42	9	2
Physical Handicap	Nil	220	46	41
	a	31	6	14
	b	36	8	6
	c	27	6	5
Behaviour Handicap	Nil	207	44	40
	m	68	14	19
	M	39	8	7
Deafness	Nil	270	57	56
	d	20	4	7
	D/B	24	5	3
Epilepsy	-	65	14	14
Occupation Estimate	i	43	9	10
	ii	73	15	13
	iii	81	17	17
	iv	67	14	18
	v	50	11	8
Promoted	-	27	6	6
Discharged	-	45	9	7

The description of handicaps and their severity is discussed in Chapter 2. A summary is given on page 24 and, for convenience of reference, a copy of the summary is printed on the bookmarker.

The first column of Table 7.I gives statistics of handicaps concerning the 314 people of the complete research survey. The second column shows the statistics of an average group of 66 people obtained by calculating 66/314ths of the first column. This is for comparison with the statistics for the 66 people who are the subjects of the present chapter.

Comments

(1) The proportion of women compared with men in the At Home group is considerably higher than that of the average sample. It seems natural to find that more women stay in the parental home situation.

(2) Other differences between the At Home group and the average group are quite small:- a few more people at home are blind and have no intellectual handicap and there are a few less people at home with no physical and no behaviour handicaps.

Eight Exceptional Cases

It has been convenient, for the purposes of study and reporting, to divide the whole group of former pupils into the fairly homogeneous groups which form the subjects of the various chapters. I had intended that the people in the present chapter would be those living in their parents' homes with no occupation except occasional attendance at handicraft classes and social gatherings. Although 58 of the 66 people do live in their parents' homes, I have included eight other people who, for a variety of reasons, live elsewhere. These reasons are the death of parents, incompatibility between parents and their sons and daughters and, also, the desire of some handicapped persons to live independently. These eight people highlight the important problems of residential accommodation, parental responsibility, etc., which have already been met in several other chapters and will be discussed generally in Chapter 9.

Miss K.H., aged 27, lives in a Local Authority Hostel for Mentally Handicapped Women. She is totally blind and has an intelligence rating of (B). She is the only visually handicapped person in the hostel. She has always been — and still is — very emotionally disturbed and the home situation has always been difficult, with mother having occasional nervous breakdowns. Miss K.H. has three half-day sessions per week at an occupation centre, but does no really effective work. Nevertheless, this occupation plus her residence in the hostel prevent the hospital placement solution of the young lady's problems having to be sought.

Mr. D.E., aged 31, lives in a Local Authority's Blind People's Home. He is totally blind, has a hearing loss and is of intelligence rating (A). Both his parents have been dead for several years and for a time he was in the care of an elderly relative. For a period of about two years he was resident at Leatherhead but proved too difficult in behaviour to be retained there. His behaviour problems are now less severe and he manages comfortably at the Old People's Home. Attendance of two days per week at an associated Occupation Centre is of considerable help, even though its activities are mainly at diversionary level.

Miss B.I., aged 28, lives in a foster home for four mentally handicapped women maintained by a charitable organisation. She has some useful vision but is not very certain in its use in unusual situations, so it has been scored as partially blind. She tends to be slow in movement and thought and has an intelligence rating of (B). Her handicaps are an aftermath of tubercular meningitis in infancy and are typical of several ex-pupils who were affected this way. She attends an Occupation Centre four half-days per week and she takes her part in the household chores of the home, which is a house on a housing estate.

Mr. G.I., aged 31, was promoted from Condover at the age of 13½ to a school for the blind. He is totally blind and has no other marked handicaps. Nevertheless it is clear that as an adult he passed through a severe period of emotional disturbance. After a not very successful training as a brush maker, he never really settled down to work and he did not get the support he needed from his parents when he was in a somewhat depressed condition. Eventually, at the age of 29 he had a period of rehabilitation at a centre organised by the R.N.I.B. Here he met a newly blinded widow who befriended him and invited Mr. G.I. to her home for a holiday. G. has stayed there ever since and the lady has continued the rehabilitation which began at the centre. She says that the help and training she has given to G. has helped her to overcome the effects of her own loss of sight. He is now in the frame of mind that he would like the opportunity to work again.

Four other people, although their sole financial income, apart from a small income as a Saturday evening newspaper vendor for one man, is the Social Security allowance, have all been granted independent Local Authority living quarters — an imaginative solution of the residential problem.

Mr. O.Q., aged 36, is partially blind, has an intellectual handicap (A), is spastic in his left limbs, particularly in the arm and hand (I have rated his physical handicap as (a) on my scale), and has a history of epilepsy though he has not had a fit for five years. When his mother died about six years ago, he quarrelled with his father and it is not clear if O. left his home voluntarily or was turned out by his father. After a period of uncertainty he was granted a small ground-floor council flat. He owns all his furniture and is a proud householder. He is granted a Home Help one morning per week, but O. does some housework, manages his own laundry and carried out some simple cooking, mainly based on simple deep-fry meals. A Social Welfare Officer for the Blind makes a short, but effective, visit every fortnight. O. attends a Methodist Chapel, is a keen member of a club which it runs, and Chapel members are very helpful to him. A few relatives live in the neighbourhood, but he only has regular contacts with an aunt whom he visits fortnightly at her home four miles away. O. walks a fair amount and uses buses effectively, having a good knowledge of the local geography.

At one time he had a daily newspaper stand, but now he works on Saturday evening only, earning 70p. O. says, rather vaguely, that he would like to work. The only available Day Centre is an A.T.C., but he will not attend this because he does not wish to "go with the mental". I think this is unfortunate since, if he attended the centre, the occupation would decrease the day-time boredom of which he complains, and the placement might lead to more remunerative work — though this is a rather remote possibility.

Miss D.G., aged 26, is deaf and blind. As a child she was able to hear well enough to make effective use of a hearing aid and to learn to speak. Now her speech is still fairly intelligible, but she cannot hear speech effectively and really needs to use the deaf-blind manual. D. is of normal intelligence and she has always wanted to achieve social and economic independence. Emotional involvement has hindered training and placement and D. has not been able to accept realistic, reasonable solutions which fell short of her desire to work with horses or handicapped children. She lives alone in a council two-bedroomed house. She can carry out housework, prepare hot drinks and cold meals. Her mother, who lives 200 yards away gives some help and Local Authority officers are helpful. D. gave up working in a Sheltered Workshop and a job seems a rather distant prospect. I think she should attend a Day Centre, which would keep her needs and her abilities under review — and provide a cooked meal five days per week!

Mr. S.H., aged 37, has rented a council flat in a tower block for several years. When he first took the flat he was working and he has continued in it during four years of unemployment. He is totally blind, of above average intelligence, and physically handicapped. His parents separated when he was very young and, until the age of 11, was seriously physically handicapped (c). Operations and his own efforts at rehabilitation led to an improvement to (a). He now feels that his physical handicap is worsening. He trained as a shorthand typist and had several good posts. Mr. S.H. always wanted to "better himself" but had the frustrating experiences of finding that professional training was deemed unsuitable because of his handicaps. He says he would like to work again, but I wonder whether he will do so. He is quite heavily involved in voluntary social work particularly with an association known as "Children's Leisure Activities". This, together with reading, study, and the fact that he

is a qualified and licensed Radio Amateur, give him such a full life that, provided he can manage financially on Social Security allowances, he might well continue as he is. He is surprisingly effective in house-keeping.

Miss K.C., aged 31, now lives in a rented council flat after having lived for some years in a rented, privately owned flat. She did not complete her training for sheltered occupation in a workshop for the blind and she has never worked. She did not return to her parents' home because of difficulties with her stepfather. She is partially blind, is ranked (A) for intellectual handicap and is mildly emotionally disturbed. K. appears to resent the official help and advice which she would really need if she is to find the work which she says she would like. She has a small circle of friends who are helpful. I have not seen her council flat but I saw her previous flat, which she seemed to organise independently and efficiently. This, plus her school performance prove that she has some work potential. However, she seems to have no real desire to work.

Ex-pupils' Satisfaction with Their Present Situations

By means of a questionnaire addressed to ex-pupils and through personal interviews, I have assessed the subjects' own opinions about their present situation as far as occupation is concerned. My findings are summed up thus:-

29 seem to be satisfied with things as they are;
37 would like more occupation.

I qualify the satisfaction with the use of the word "seem" because, in seven or eight cases the decision was difficult. The issue was complicated by either parental domination or the unresponsiveness of the most seriously handicapped people.

Individuals and Their Handicaps

So far, in this chapter, I have given some statistics on the prevalence of handicaps in an impersonal way, though I have related handicaps to persons in describing eight people in exceptional circumstances. I have also reduced the personal wishes of the 66 people who are the subjects of this chapter to two simple statements. It would be too lengthy a process for me to give detailed case studies of all these people and yet I feel that I would be failing in my reporting if I aimed at being too impersonally statistical. The strength — or weakness — of my enquiry is that I know all the people who are its subjects.

To help my presentation of personal situations and also to give some idea of the complexity of the handicap situation I have prepared Table 7.II, which summarises a considerable amount of information. Individuals are indicated by initials which are not their real initials. May I remind readers that the bookmarker gives a summary of my scoring system.

Table 7.II Individuals' Multiple Handicaps (N=66)

Intellectual Handicap	Visual Handicaps					
	PS		PB		B	
Nil	Miss B.T.	None	Mr. N.C.	None	Miss F.G.	None
	Mr. E.V.	E	Miss A.T.	a	Mr. G.I.*	None
	Mr. H.E.	D/B	Mr. D.I.	a	Miss N.N.	a
					Mr. T.Q.	a
					Mr. S.H.*	a m
					Miss D.X.	a d
					Miss L.L.	b m
					Mr. S.X.	b m
					Mr. Q.F.	m
					Miss D.G.*	m D/B
					Mr. E.D.	M
					Mr. C.U.	M E
					Miss S.C.	e
					Mr. K.E.	E
A	Mr. I.F.	b	Miss C.J.	None	Miss N.D.	None
			Miss Q.D.	a	Miss M.T.	None
			Miss P.C.	a M	Mr. H.S.	None
			Mr. D.N.	a D/B	Mr. F.T.	None
			Mr. O.Q.*	a m e	Mr. G.Z.	None
			Miss I.A.	b m	Miss T.I.	b
			Miss R.E.	b m E	Mr. B.C.	c d
			Miss K.C.*	m	Mr. B.D.	c d E speech
			Mr. H.K.	m E	Miss M.Q.	m
					Mr. D.E.*	m d
					Miss T.C.	m E
					Miss V.P.	d
					Mr. E.L.	d
					Mr. B.T.	d E
B	Mr. E.T.	None	Miss F.C.	None	Miss E.M.	None
	Mr. B.N.	a	Miss X.C.	None	Miss F.M.	None
	Miss N.G.	a speech	Mr. D.Q.	None	Miss K.H.*	M
	Mr. W.F.	c speech	Miss U.T.	a	Miss A.M.	M
	Miss C.T.	m	Miss K.D.	c M E		
	Mr. B.D.	m	Miss B.I.*	m		
	Miss H.T.	M e	Mr. Q.E.	m		
			Mr. N.U.	m		
			Miss O.D.	d		
C					Miss T.E.	a m E
					Miss E.D.	c E speech

Notes: The asterisk (*) indicates people already dealt with as Eight Exceptional Cases. Underlining indicates individuals who desire more occupation.

Interpretation of the Table

Within three columns indicating the three categories of visual handicaps PS, PB, and B, and four lines of intellectual handicaps Nil, (A), (B), and (C), are shown each individual's combined visual and intellectual handicaps. In each rectangle I have used initials to indicate each person and have added the usual symbols to indicate individuals' additional handicaps. In each rectangle the handicaps are mentioned in a regular sequence: none, physical, behavioural, deafness, epilepsy, and speech defects, proceeding from less severe scores to more severe. As examples, in rectangle (A)/PB which concerns people who have a

moderate intellectual handicap and are partially blind, we see that Miss C.J. has no other handicaps, Miss P.C. has a moderate physical handicap and a severe behaviour handicap; and Mr. O.Q. has a moderate physical handicap, a fairly severe behaviour handicap, has a history of epilepsy, desires more occupation and has already been mentioned as an exceptional case.

From the information in Table 7.II it is possible, therefore, to work out the handicaps of all the 66 people. Although this brings us nearer to the individual people than does a statistical statement of handicaps there are still many factors which distinguish one person from another: personal characteristics such as temperament, appreciation of awareness of reality, the effects of the handicaps on the achievement of personal independence, etc. Also there are parental attitudes and opinions and the indefinable atmosphere of a home. In addition, there are my own attitudes towards the people concerned, most of whom are, in a way, friends of mine, so I could easily be swayed by undue emotion.

Parents' Satisfaction with the Occupation Situation

Before dealing with case descriptions I will add another item of information which I wish to include in the discussions. Through personal interviews and questionnaires I have estimated parents' satisfaction with the situation of their sons and daughters with regard to occupation. There was a choice of three levels of satisfaction, the summary of parents' responses being:- "satisfied" — 21, "fairly satisfied" — 22, "not satisfied" — 17. (Six subjects have no parents.) The individual responses of parents will be indicated in a column in Tables 7.III to 7.VI.

Case Descriptions

I now proceed to a systematic presentation of case descriptions aimed to cover the whole of the 66 people in this chapter. I have divided the ex-pupils into four groups based on Table 7.II:-

22 people of all types of visual handicaps with intellectual handicaps (B) and (C);
16 people with some vision with no intellectual handicap or handicap (A);
14 blind people with intellectual handicap (A);
14 blind people with no intellectual handicap.

Each group will have a table of personal statistics showing each person's handicaps with extra information on the opinions of parents and of the handicapped people on the occupation situation.

Although I do not claim to be correct in all my opinions I shall put forward my own assessment of individual situations and these are sometimes contrary to the opinions of ex-pupils and their parents. To super-impose my own opinions on the case description procedure, I have divided each of the four groups into five sections. In each group, section (a) will include people for whom I think no change is necessary and section (e) will be concerned with special cases. Although there are different headings for sections (b), (c), and (d) in the different groups, they are always concerned with people for whom I suggest some change.

N.B. Symbols used in Tables 7.III to 7.IV are:-
for handicaps and occupation estimates — as used throughout the research.
Column (1): (a) to (e) indicate the sections for presentation of case descriptions; underlining of initials indicates people who say they would like more occupation; asterisks indicate people dealt with earlier as exceptional cases.
Column (10) (Parental Satisfaction): S — satisfied; F — fairly satisfied; N — not satisfied; N/A — no parents.

(1) Table 7.III People with Intellectual Handicaps (B) or (C) (N=22)

	Age	Handicaps						Occupation	Parents'
		Visual	Int.	Phys.	Beh.	Deafness	Epilepsy	Estimate	Satisfaction
(a)									
Mr. B.D.	40	PS	B	-	m	-	-	v	N
Mr. E.T.	26	PS	B	-	-	-	-	iii	F
Miss C.T.	35	PS	B	-	m	-	-	v	F
Miss E.D.	33	B	C	c	-	-	E	v	S
Miss N.G.	37	PS	B	a	-	-	-	iii	S
Miss F.C.	34	PB	B	-	-	-	-	ii	S
Mr. D.Q.	41	PB	B	-	-	-	-	iv	F
Miss U.T.	22	PB	B	a	-	-	-	iii	S
(b)									
Mr. B.N.	35	PS	B	a	-	-	-	iv	S
Miss B.I.*	28	PB	B	-	m	-	-	iv	N/A
Miss K.H.*	27	B	B	-	M	-	-	iv	F
Mr. Q.E.	29	PB	B	-	m	-	-	iv	F
Miss X.C.	19	PB	B	-	-	-	-	iii	N
Miss A.M.	34	B	B	-	M	-	-	v	F
(c)									
Miss O.D.	31	PB	B	-	-	d	-	iii	N
Mr. W.F.	24	PS	B	c	-	-	-	v	F
(d)									
Mr. N.U.	23	PB	B	-	m	-	-	iv	S
(e)									
Miss E.M.	25	B	B	-	-	-	-	iv	S
Miss F.M.	25	B	B	-	-	-	-	iv	S
Miss K.D.	22	PB	B	c	M	-	E	v	N
Miss T.E.	27	B	C	a	m	-	E	v	S
Miss H.T.	21	PS	B	-	M	-	e	iii	S

In the chapter concerning Day Centres I argue strongly that any ex-pupils at these low levels of intellectual ability would find themselves very suitably placed in Adult Training Centres for the Mentally Handicapped. If such a centre is available for some of the 22 people in Table 7.II I would recommend placement there. Simple occupation is available and often social and practical programmes are provided. Attendance is usually for five days per week with consequent reduction of boredom for the handicapped person and daytime relief is provided for the mother. I know that some parents have refused the offer of such a placement for their son or daughter but I would hope that they will change their mind, and, if they do so, that places will be available.

(a) Eight People for whom no Change is Necessary

Mr. B.D. was discharged from school because of frequent aggressive outbursts. He has quietened considerably, though I think he should be considered to have a behaviour handicap (m). He is reasonably well controlled and he very much likes his part-time farm work and his hobby of tending his widowed mother's fair-sized garden. Although he is listed as wanting more occupation, there seems no reason to change a satisfactory situation unless he can get more work on the farm. Mr. B.D. lives with his elderly widowed mother who is worried about the future when she can no longer care for her son, but she has several other married sons and daughters in the neighbourhood.

Mr. E.T. was unhappy — and rather frightened — at an A.T.C. where some hospital patients attended. This may have been an irrational re-action but the lasting impression on E. is still vivid and upsetting. Fortunately he has found part-time work helping with a country milk-round, which he manages well, having some useful sight.

Miss C.T. was discharged from school because of very severe behaviour handicaps. She was almost uncontrollable and she inflicted injuries on herself. She was partially blind and I rated her as having intellectual handicaps (B) and behaviour handicaps (M) and I really thought C. would need prolonged hospital treatment. I have not had time or opportunity to attempt a detailed case history: all I am sure of is that Miss C.T. has had considerable help from the Home Teachers of the former Blind Welfare services and this has continued, fortunately, into the amalgamated Social Services of the present day much better than has often happened elsewhere. There has been continuing personal involvement of the same Welfare Officer. Miss C.T. has also profited from a course of social rehabilitation at one of the R.N.I.B.'s centres. C. now acts as housekeeper for her widowed elderly father, though he helps with the housework. My wife and I were welcomed warmly by Miss C.T. at her father's home where she was alone at the time. Soon she offered us tea, which she made effectively, and cake which she had made herself — it was a little burnt, but quite palatable. After a time she revealed, incidentally, in conversation and on the verge of tears, that she has still a behaviour handicap. "I smoke too much.... because I'm on my own too much.... I want to get away from this place.... I want to get more education." She regretted "being so silly and awkward at school." For "her nerves" she has "some green capsules" and "valium for sleeping". These remarks were largely outpourings from C., unprompted by me. On the positive side, Miss C.T. keeps the house fairly tidy; does some floor-scrubbing for a local Doctor; attends one handwork centre one day per week and another handwork centre for one day per fortnight; is a member of an Old Time Dancing class in her village, travelling there and back alone. Four married siblings live in the fairly near neighbourhood — up to about four miles distant — and C. is trusted to do some baby-sitting. The day of our interview coincided with her fortnightly visit to a friend who lives four miles away, so we took her to her friend's house by car. Normally she would travel by 'bus. C. demonstrated that her sight has improved, by pointing out a number of landmarks, houses, etc. Although at school I considered her as being partially blind, now she seems definitely partially sighted. Miss C.T. cannot really be described as having "little or no occupation", but this chapter seemed the most appropriate one in which to discuss her. While she can remain in her father's home, she seems fairly secure, in spite of her emotional outbursts about wanting to get away, etc.

Miss E.D. who is very severely multi-handicapped, lives with her widowed mother who gets some help and companionship from an unmarried sister who lives nearby. Mrs. D. has always wanted to care for her daughter and she wishes to continue to do so. She is much reassured because her Social Services Department have indicated the kind of accommodation her daughter can be admitted to when a crises arises.

Similar reassurance has been given to Mrs. G. mother of Miss N.G., by her Social Services Department. N., attends occasionally at social and handicraft classes which give her a pastime occupation at home. She spends a full leisure life with her widowed mother and two "aunties".

Miss F.C. lives with her widowed mother. F. is very small in stature and has a mildly disfigured face and hands of which she is very conscious and this hinders social contacts. She does not wish to attend a centre. Although mother and daughter live a restricted life they provide each other with companionship and there are other members of the family who keep in contact.

Mr. D.Q. does some simple canework at a handicraft class and continues this work at home. He walks great distances — of the order of ten miles — in the countryside and even has his own old rowing boat on a safe stretch of water. He is a happy, rather solitary, eccentric man.

Miss U.T. has a moderate physical handicap. She once went to a nearby A.T.C., where she could still attend, but she quarrelled with other members of the centre and refuses to return. The upset was a very minor matter but her parents are content for U. to stay at home, and this seems satisfactory for the time being.

(b) Six People who Should Increase their Attendance at Centres

This is a straightforward recommendation. Special notes are necessary for one person only.

The last of this group of six, Miss A.M., presents grave problems to her parents and all people who deal with her. She has a very severe behaviour handicap (M) which takes the form of unco-operative behaviour often accompanied by quarrelling and frequent repetition of nonsensical phrases or bad language which can be a severe social embarrassment as also is her insistence in continuing to talk in church and concerts. Her parents have tried hard to make A. socially acceptable and have sought help from several sources, but her condition has not responded to psychiatric treatment, and her positive non-co-operation has caused difficulties in centres. When at her best, she can be charming in a rather unreal, formal fashion. Her latest placement in the A.T.C. with a sympathetic staff may well prove to be the most hopeful development ever.

(c) Two People who would like to Attend a Centre and Should do so

Mr. W.F. has a very severe physical handicap, but can use a wheel chair, and he has a speech defect. He is a very sociable young man and wishes to have more interest than he now has.

Miss O.D. has a minor hearing handicap. She was quite good practically at school. At the time of my personal interview I took O. and her mother to the local Social Services Area office and it seemed that attendance at an A.T.C. might be arranged as the city has several such centres. However, unfortunately, there have been no developments.

(d) One Person whom I Consider Should be Persuaded to Attend a Centre

Mr. N.U. has a moderate behaviour handicap (m) which has contributed to his return home after a trial residential placement and, also, to his refusal to attend two local centres. N. is the eldest of five children in a family which is haphazardly organised but provides affection and a lively, if confusing, atmosphere. It is regrettable that, in a town with a well organised Social Service Department with appropriate Day Centres, Mr. N.U.'s parents do not bring some pressure to bear on their son to profit from the opportunities available, and which have been offered.

(e) Five Special Cases

A common factor with the cases of these five people is the great efforts made by the parents, particularly the mothers, to keep their daughters at home. In spite of this I consider that changes in the present situation are urgent.

The twins, Misses E.M. and F.M., have a severe intellectual handicap but no other handicaps additional to their blindness. I respect the parents for their efforts but there is a large element of over-protection in their caring and I suspect that Mrs. M. feels the strain at times. The solution could be simple, since an A.T.C. is available where the young ladies would have the companionship of people of their own age and the help of skilled and understanding staff.

Miss K.D. is very demanding of attention and her mother is almost completely involved in her daughter's care. I get the impression that the strain of this intensive care is reaching the breaking point. K. needs physical "manhandling" because of her severe physical handicaps, has frequent bouts of obstinacy and irrational outbursts of emotion and has fairly frequent petit mal attacks. I doubt if an A.T.C. could cope with K.'s problem and the best solution would be her admission to hospital. If Mrs. D. became ill there would be no option, K. would have to go to hospital.

Miss T.E., aged 27, is severely multi-handicapped and the parents have a severely handicapped spastic son living at home also. The parents can afford to pay for some relief help but the strain is great, nevertheless, especially on Mrs. E. In this case there is certainly no A.T.C. available and I feel that the best solution is for T. to be admitted to hospital. I suppose neither Mrs. D. nor Mrs. E. would agree with me, but hospital conditions are improving and their daughters might be reasonably happy in residence there.

Miss H.T. has a severe behaviour handicap (M). This takes the form of occasional bouts of mental illness which, as far as I know, has not been diagnosed. She came to Condover from a hospital for the severely subnormal and at school leaving age was re-admitted there. H.'s parents withdrew her from hospital and now keep her at home, and say they and their daughter are well satisfied with this situation. I feel worried about it since mother has a history of nervous breakdown. Also H. seemed to be doing well in hospital and was occupied in industrial therapy. She stated in the questionnaire filled in on her behalf that she is often bored and would like many more things to do. This seems a danger signal and the remedy would be to try attendance at an A.T.C.

(2) Table 7.IV People with Some Vision and Intellectual Handicaps Nil or (A) (N=16)

	Age	Handicaps						Occupation	Parents'
		Visual	Int.	Phys.	Beh.	Deafness	Epilepsy	Estimate	Satisfaction
(a)									
Miss B.T.	37	PS	Nil	-	-	-	-	i	S
Miss C.J.	40	PB	A	-	-	-	-	ii	S
Miss Q.D.	31	PB	A	a	-	-	-	i	F
Miss K.C.*	31	PB	A	-	m	-	-	ii	N/A
Miss A.T.	30	PB	Nil	a	-	-	-	ii	F
(b)									
Mr. E.V.	38	PS	Nil	-	-	-	E	i	F
Mr. H.E.	22	PS	Nil	-	-	D/B	-	ii	N
Mr. N.C.	30	PB	Nil	-	-	-	-	i	F
Mr. D.I.	23	PB	Nil	a	-	-	-	iii	N
(c)									
Mr. I.F.	30	PS	A	b	-	-	-	iv	S
Miss R.E.	32	PB	A	b	m	-	E	iv	N
(d)									
Miss I.A.	34	PB	A	b	m	-	-	iv	S
Mr. H.K.	30	PB	A	-	m	-	E	iii	F
Mr. O.Q.*	36	PB	A	a	m	-	e	iii	N/A
(e)									
Mr. D.N.	25	PB	A	a	-	D/B	-	ii	N
Miss P.C.	20	PB	A	a	M	-	-	iii	F

(a) Five People for whom no Change is Necessary

All five are aged 30 or above and have achieved a pattern of living which is reasonably satisfying to them, justifiably so in my opinion. I give a case description of one person only, because of the interesting developments in her situation.

Miss A.T. has developed an interesting leisure time programme and has done some study which led to one 'O' level success. For several years her main interests have centred around the Sheffield P.H.A.B. Club of which she is an active and leading member. She is one of the members of a club committee which, for three or four years, has been trying to persuade the Local Education Authority to set up classes for disabled adults. By means of petitions and a demonstration the club members have achieved some success. The Education Authority have agreed to set up in the autumn of 1974 an experimental, exploratory six-week course for disabled adults at a College of Further Education with a view to ascertaining realistic needs. If the disabled people succeed in making a case, the Authority will either provide special classes for the disabled or will assign disabled individuals to existing classes for the non-handicapped or, presumably, will carry out both projects. Miss A.T., on whom I have relied for my information, has said to me, "We disabled people mature slowly" and I think that she is hoping that this new educational development will have vocational training possibilities which could lead to her — and others — finding employment.

(b) Four People whose Work/Occupation Situation Should be Investigated

Mr. E.V. has, for many years, lived a satisfactory life at home where he is helpful to nearby relatives with household chores, child-minding, etc. He also produces and sells baskets and stools. Recently he attended a rehabilitation course and is hoping now for employment.

Mr. H.E. is classified as deaf-blind though he is not very seriously handicapped being partially sighted and partially blind. Notes on him will be found in Chapter 8.

Mr. N.C. is in a difficult position. He would really like to leave his parents' home. He has a part-time, ill-paid, job as a news vendor. In the area in which he lives employment suitable for him is difficult to find. He has, however, extensive and time consuming church and religious interests which he enjoys. He was married but he is now separated from his wife. His urgent need is some rented accommodation so that he can live independently, like some of the eight exceptional people.

Mr. D.I. is partially blind, has no intellectual handicaps and a moderate physical handicap. He needs a period of rehabilitation which would also assess his work potential. Such a course is available but it is resident and about 200 miles away. His parents would object to him going away from home, but he tells me he would like to go. Action here seems urgent.

(c) Two People who Need more Time at Centres

Although Mr. I.F. has no desire to change his present situation of attendance at a centre for one day per week, I consider that he needs more occupation.

Miss R.E. would like to attend a centre more frequently. She is quite seriously multi-handicapped and more attendance at the centre would help relieve her boredom and reduce the strain on her parents, particularly her mother. R.

has a behaviour handicap which could well increase if she does not find more occupation.

(d) Three People who Should Attend a Day Centre

I suspect that the two men would object to attendance at an A.T.C. which, at present, is the only type of centre available for them.

Mr. O.Q. has already been described among the eight exceptional cases (page 182). His case is extremely interesting and readers may find it illuminating to re-read the description of the situation.

Miss I.A. is partially blind and has a moderate intellectual handicap. Her behaviour difficulties stem, I think, from her hydrocephalus which itself arises from meningitis contracted in infancy and this caused her other handicaps too. Like some other ex-Condover pupils Miss I.A. has many of the traits of vagueness and uncertainty in movement, attention, memory and connected thought which I associate with the hydrocephalic condition. When I was interviewing her and had expressed surprise at her detailed recall of a person at Condover whom she had not seen for 20 years, she said, ruefully, "I can remember lots of things which don't matter and can't remember important things, like things mother tells me to do." Miss I.A. is very dependent on her parents, particularly her mother. In her case I feel that this dependency is necessary and mother stimulates her daughter into a considerable amount of activity including walking, in which she has to be accompanied and needs occasional physical support, helping with housework, the use of a talking book, etc. Mrs. A. would welcome her daughter's attendance at a Day Centre but none is available. I think occasional short stays for Miss I.A. at a hostel would benefit both mother and daughter but this type of facility is also not available locally.

Mr. H.K. has a behaviour handicap (m) and suffers from occasional epilepsy. His hands, particularly the left, are very clumsy but I decided not to rate this as a physical handicap — a borderline decision. His parents, particularly his mother, are very patient with their son's limitations. Much has been done to help H. feel independent. He is allowed much freedom of movement about the town where he lives in spite of his epilepsy. He has a radio "den" with much apparatus specially devised for his ease of manipulation. His main difficulty is a selfish single-mindedness often accompanied by great stubbornness and rudeness, which I experienced when he told me emphatically that he would not consider attendance at a new local A.T.C. so he continues to live at home. Mrs. K. would like her son to have occasional holidays away from home, or for someone to supervise him at home while she and her husband had a holiday. This would be partly for parental relief, but also with the positive objective of giving H. experience of trying to live more independently.

(e) Two Special Cases

Mr. D.N. Notes on this seriously handicapped deaf-blind young man will be found in Chapter 8. Investigation of his situation is urgently needed.

Miss P.C. has a moderate physical handicap. Her behaviour difficulties are very different from all the others I have rated as (M). Except under special circumstances, and these always with members of her family, P. just does not talk. She shows by smiles and slight nods that she understands what is said to her. From the age of 13 she spent three years at Condover and we enjoyed her stay there but no member of staff heard her speak. I do not doubt her verbal communication with her family because when a brother visited P. he told me something about his sister which he could only have learned via speech from her.

The speech is mainly through the use of single words or simple phrases. Her condition was once described as 'elective mutism' but one psychiatrist said that P.'s cheerfulness was not in keeping with such a condition. I have rated P.'s vision as partial blindness basing this on observation, since she carried out carefully executed colour patterns in fairly fine embroidery canvas. No ophthalmic surgeon has stated, at a clinical examination, that she has any visual acuity at all. A Social Services Officer brings handwork materials for P. to work with at home, but when I last heard, she was not attending any class or centre. There is a strong case for attendance to begin.

Special Note on the Blind People in this Chapter

I draw attention to the comparatively large number of blind people with either no intellectual handicap or with only the moderate handicap (A). This was clearly shown in Table 7.II, where it can be seen that 28 of the 34 blind people have intellectual handicaps Nil or (A). Of the 32 people with some vision only 16 are of these two categories of handicap. I offer two explanations of the high incidence of blind people in the group of people with little or no occupation.

(a) It must be accepted that many of the 28 are incapable of either open or sheltered employment because of their additional handicaps. Lack of sight is, of course, a difficulty when employment is considered, but many blind people develop effective sensory compensation for their blindness and are effectively employed, including some Condover ex-pupils. Some blind people through causes unknown seem unable to develop this sensory compensation and I illustrated this by my case descriptions of Mr. H.S. in Chapter 5, page 128. I have also made comments throughout the report on this abnormally poor development of sensory compensation which almost amounts to an additional handicap to blindness and it affects several people among the 28 whom I shall soon be describing.

(b) As far as occupation is concerned the alternatives to employment are some kind of specially devised occupation or attendance at a Day Centre. Since there are many more Adult Training Centres for the Mentally Handicapped than Other Day Centres for other types of handicapped people, often an A.T.C. is the only one available. Even if some of the 28 people were deemed officially suitable for an A.T.C. there is the reluctance of individuals to attend such a centre.

In considering the situations of the 28 blind people I have divided them into two groups according to the degree of their intellectual handicap, i.e. the third and fourth groups of my case descriptions.

(3) Table 7.V Blind People with Intellectual Handicap (A) (N=14)

	Age	Handicaps						Occupation	Parents'
		Visual	Int.	Phys.	Beh.	Deafness	Epilepsy	Estimate	Satisfaction
(a)									
Miss M.T.	21	B	A	-	-	-	-	iv	S
Miss T.C.	37	B	A	-	m	-	E	iii	S
Miss T.I.	39	B	A	b	-	-	-	iv	S
Mr. B.T.	36	B	A	-	-	d	E	i	F
(b)									
Mr. G.Z.	23	B	A	-	-	-	-	i	N
Miss V.P.	26	B	A	-	-	d	-	ii	N
(c)									
Miss N.D.	22	B	A	-	-	-	-	ii	N
Mr. E.L.	23	B	A	-	-	d	-	iii	N
Miss M.Q.	24	B	A	-	m	-	-	iv	F
(d)									
Mr. D.E.*	31	B	A	-	m	d	-	iii	N/A
Mr. H.S.	29	B	A	-	-	-	-	iv	F
(e)									
Mr. F.T.	23	B	A	-	-	-	-	iv	F
Mr. B.C.	30	B	A	c	-	d	-	iii	S
Mr. B.D.	20	B	A	c	-	d	E	v	F

(a) Four People for whom no Change is Necessary

The parents of Miss M.T. are adamant that their daughter shall live at home. No occupation centre is available in the neighbourhood where she lives. M. is a placid very impractical young woman and she happily accepts the position.

Miss T.C. has active epilepsy and she now suffers from diabetes. After an unsuccessful period in a residential home, she has spent nearly twenty years living at home. Her parents have a village business and some farming interests. T. has been absorbed as far as possible into these activities and, although her behaviour is difficult at times and she is so seriously multi-handicapped, life is reasonable for her and her relatives.

Miss T.I., aged 39, is certainly satisfactorily situated as she is at present, as long as her elderly parents can care for her. She is musical and helps at socials for handicapped people. Although T.'s parents are worried about the future they live in a county with well developed Social Services and their daughter's welfare should be secure.

Mr. B.T. has developed epilepsy since leaving school. His hearing loss is not very marked and his intellectual handicap is not serious, in fact he is at the borderline with average intelligence. He was one of the most effective blind pupils at Condover in practical subjects and in mobility. The onset of epilepsy was the chief factor in ending his period of successful open employment, and it has also adversely affected his mobility. There seems little likelihood of his resuming work.

(b) Two People who Should be at Work

Mr. G.Z. is very capable and is one of the most independent of all ex-Condover pupils and, indeed compares well with most blind adults in this matter. He owns a guide dog and uses it very competently. He worked for a time at the local sheltered workshop for the blind but left after a quarrel with the foreman. His fairly well filled leisure time centres round his effective collection of

money for the Guide Dogs Association. If he could only be found work he would become a really independent working blind man.

Miss V.P. has worked on assembly and packing in a Centre for the Blind and the Physically Handicapped. She earned the maximum permitted weekly sum of £2.00 in three short days of work. She has now left the centre and is not very actively seeking work unless she were permitted to take her guide dog. In theory, at any rate, the centre had served one of its functions — that of providing work experience for someone who could go on to work. There seems to have been some lack of liaison with the work placement services for the blind.

(c) Three People whose Work/Occupation Situation Should be Investigated

Miss N.D. attended a vocational assessment centre but is probably not a good candidate for employment because of poor sensory compensation. She has had no work or occupation for the last four years and any skills she has are likely to have deteriorated. There is no suitable occupation centre in the neighbourhood and N.'s leisure time activities are very restricted. Urgent review of her case is needed and, possibly attendance at an R.N.I.B. rehabilitation centre.

Mr. E.L. is partially deaf. Until good oral communication has been achieved with K. — and this means quiet surroundings, making sure that he has adjusted his hearing aid and hoping that he will be interested in the subject of conversation — he can appear dumber than he really is both in speech and intelligence. E, unfortunately, turned down an invitation to attend the basketry department of the local Sheltered Workshop for the Blind. He told me that he would have been bored and I realise that he is certainly no good at basketry. But, if he had accepted the invitation, it could well have led to transfer to another centre. Action to prevent E. becoming increasingly isolated is essential.

Miss M.Q., aged 24, was a very emotionally disturbed pupil at school of category (M) with irrational attitudes, emotional outbursts, etc. There has been an unexpected improvement in behaviour since she left school under circumstances which might have been considered inconducive to such improvement. She has had no form of occupation and her father, of whom she was very fond, died suddenly. Now M. lives very closely with her mother and they are almost inseparable companions. I consider the time has come for M. to attend a centre.

(d) Two People who Need More Time at the Centres where they already Attend Part-Time

Mr. D.E. has been described among the eight exceptional cases, page 181.

Mr. H.S. is a very impractical blind man who attends an A.T.C. occasionally and there is a distinct possibility that he will shortly be able to attend more frequently. His parents fostered a boy who was also a pupil at Condover and he still lives with the family, being completely integrated with it. This young man, who works in a sheltered workshop, has some useful vision; he and Mr. H.S. are inseparable leisure-time companions and, together, have many interests and travel considerable distances independently.

(e) Three Special Cases

The parents of Mr. F.T. died some years ago leaving their son some money and a small business. F. is another very unpractical blind man and is not capable of running the business himself so he is cared for by trustees. He lives with an elderly relative who is worried about F.'s future, but surely there should be a fairly simple solution to that problem? Mr. F.T.'s main need is a wider, more

interesting leisure time and some training in practical personal skills and simple mobility. He needs to attend a centre.

Mr. B.C. is also partially deaf. He is hydrocephalic, but unlike most ex-Condover pupils suffering from this condition, of whom Miss I.A. whom I described earlier is a more usual example, he is sensible, realistic and fond of interesting conversation which he supports rationally from a remarkably good memory. His physical handicaps are worse than they were at school. He is almost completely bed-ridden, cannot walk at all and, if he is placed in a wheel chair, he soon slumps sideways. He has frequent bouts of diarrhoea lasting three or four days and these are usually followed by attacks of severe constipation. Mrs. C. receives frequent help from her husband and occasional help from a married daughter but she bears the brunt of the care of her son, a burden which she carried very cheerfully. Naturally both parents view the future with some misgiving and I think they would accept a residential placement for their son if he seemed happy about it, but nothing is available. A short break for the parents so that they could get a holiday would be a great help.

Mr. B.D. is in some ways even more seriously handicapped than Mr. B.C. though he does not suffer from comparable stomach troubles. He cannot walk and only one hand has any useful movement and even this is restricted. He is much more severely partially deaf, is epileptic and has very little intelligible speech. His handicaps arose as a result of an accident at age 12 when, as well as suffering injuries, he was unconscious for two weeks. Eighteen months later he needed an operation for the removal of a brain tumour. Because of his multiple handicaps it is easy to think that Mr. B.D. is grossly intellectually handicapped also, but his parents are convinced that this is not so. B. only spent one term at Condover when he was already aged 16 and the staff felt that he had some intelligence. In the course of my research survey I spent several hours at B.'s home and realised that the parents' conviction that their son is not very severely intellectually handicapped is based on fact, not wishful thinking. The great problem is communication and a superficial view of the young man can lead to the impression that none is possible. People of good will have made suggestions as to how Mr. B.D. could be trained to communicate and to walk and what aids could be devised to help him with daily living, but the problems are immense. The best help the parents have received has been through an arrangement made by Social Services for their son to have occasional short residential stays away from home.

(4) Table 7.VI Blind People who have no Intellectual Handicap (N=14)

	Age	Handicaps						Occupation	Parents'
		Visual	Int.	Phys.	Beh.	Deafness	Epilepsy	Estimate	Satisfaction
(a)									
Miss F.G.	37	B	Nil	-	-	-	-	i	S
Miss D.X.	30	B	Nil	a	-	d	-	iii	S
Mr. S.H.*	37	B	Nil	a	m	-	-	ii	N/A
(b)									
Miss S.C.	33	B	Nil	-	-	-	e	i	F
Mr. T.Q.	23	B	Nil	a	-	-	-	i	N
(c)									
Mr. G.I.*	31	B	Nil	-	-	-	-	ii	N/A
(d)									
Miss N.N.	31	B	Nil	a	-	-	-	iv	F
Mr. K.E.	23	B	Nil	-	-	-	E	iii	N
(e)									
Miss D.G.*	26	B	Nil	-	m	D/B	-	ii	N
Miss L.L.	25	B	Nil	b	m	-	-	i	F
Mr. S.X.	23	B	Nil	b	m	-	-	iii	S
Mr. Q.F.	24	B	Nil	-	m	-	-	ii	F
Mr. C.U.	29	B	Nil	-	M	-	E	ii	N
Mr. E.D.	29	B	Nil	-	M	-	-	iv	N

(a) Three People for whom no Change is Necessary

Miss F.G. is the woman described earlier who, after 11 years of arduous work in open industry has, justifiably, decided to take a rest.

Through the help of friends, and greatly aided by her own initiative, Miss D.X. has built up an interesting leisure time programme which gradually came to be centred on study courses. She took some 'O' level courses by private study, then attended part-time at a local College of Further Education. In the autumn of 1973 at the age of 29, she began full-time study at Hereward College of Further Education for the Physically Handicapped as its first blind physically handicapped student. She has been given the three-year objective of accumulating examination successes which would qualify her for university entrance. In the last two years a new treatment for her physical handicap, an unusual and severe type of arthritis, has led to remarkable improvements in Miss D.X.'s mobility and she can now use 'buses independently. There is a considerable reduction in the pain she used to suffer. Nevertheless employment does not yet seem a realistic possibility. She has very recently married a visually handicapped man and, when they have set up home, she will move from the category of "living with her parents". The married couple will receive Social Security allowances and D. will continue her full-time studies.

Mr. S.H. is the man with exceptional abilities whom I have described among eight exceptional cases, page 182.

(b) Two People who Should Work

Miss S.C.'s blindness was due to meningitis at age 11. She spent two terms as a period of rehabilitation at Condover and at age 13 she was promoted to a school for the blind. Then she studied typing and braille shorthand at home and later at a local college. She has never found employment, yet she is a sensible, competent woman who lives a full life. The meningitis seemed to have affected her orientation causing her difficulties with mobility. However, she now has a

guide dog and is very independent in travel. I am sure she could work, since socially and intellectually she is very much alive. She needs a brief re-training course followed by the services of a good placement officer.

Mr. T.Q. has a moderate physical handicap. He has not been able to find any vocational training. Because of his good educational progress he was promoted to a school for the blind, where his good progress continued. His physical handicap is due to a brittle bone condition. Unfortunately at school leaving age, when it could have been expected that this condition would have disappeared, he sustained a fractured leg. The treatment was lengthy and prevented him attending the vocational assessment course which had been arranged. Since then T. has been turned down by training establishments for the blind because of his physical handicap and by an establishment for the physically handicapped because of his blindness. A Social Welfare Officer who is herself blind has persisted for several years on T.'s behalf and in the last year arranged a full physical investigation for him. This is well under way and the future is beginning to look hopeful because his physical handicap may well be considerably reduced and the brittle bone condition may have disappeared.

(c) One Person whose Work/Occupation Situation Needs Investigation

Mr. G.I. has been described earlier among Eight Exceptional Cases. (Page 181.)

(d) Two People who Need to Attend a Centre

Miss N.N. has a full leisure-time programme. After several years in a residential placement she decided to return to her parents' home where she leads an independent life. Recently she has started attending a Day Centre for the Physically Handicapped and the Blind. This may well be a period of rehabilitation leading to permanent occupation though open employment is very unlikely.

Mr. K.E. is blind, has no intellectual handicap but has occasional epileptic fits — only about two per year. K.'s real handicap is his strange inability to compensate for his blindness. Although he is certainly not mentally handicapped I am sure he would attend the nearest A.T.C. where there are a few other non-mentally handicapped members, but he is outside the centre's bus collection radius.

(e) Six Special Cases

Miss D.G. is the deaf-blind young woman who has been described among eight exceptional cases, page 182.

Miss L.L. is blind, has no intellectual handicap — in fact her intelligence is above average — but has behaviour difficulties. The latter difficulties are mainly shown by non-co-operative behaviour which may be a by-product of the frustration caused by her physical handicap and her realisation that successful employment would only be possible after much intense effort and that, anyway, success would be by no means certain. L. abandoned a course of further education at the Royal Normal College for the Blind, where she was the only seriously physically handicapped student, after some success in academic studies (two 'O' levels) and in vocational training in commercial subjects. Her explanation for her abandonment of studying is that she became desperately tired and often wept, "and that is not my line!", she added. Now she leads a very restricted life at home. Although quite independent in self-care she is becoming, in my opinion, too dependent on her parents who are over-protective. L. could live much more independently away from home. With a little help she could manage a small flat and she should be continuing her studies. At my research interview I put her in contact with the Local Education Authority hoping that this might lead to at least

part-time attendance at the local College of Further Education, but there were no developments. Perhaps admission to the Hereward College of Further Education for the Physically Handicapped would be a solution?

Mr. S.X. who has a behaviour handicap (m) resists all efforts to persuade him to attend any centre. I suppose that it must be accepted that he must stay as he is, yet, if he were more co-operative, his life could be more interesting.

Mr. Q.F. has a behaviour handicap which I rate as (m). He was admitted to Condover at age 11 when he had severe behaviour handicaps. He was unco-operative, obsessional in behaviour and conversation, seeming far removed from reality and he had intense emotional outbursts of temper and crying. At one time we thought we would have to declare him ineducable and ask for his withdrawal from school. At age 14, however, improvements in behaviour took place and he began to make good progress in most school subjects, his best progress being made in the use of braille and in piano playing. It was decided that he should stay on at school till age 17 with a view to transferring to one of the vocational assessment courses. This duly happened but, at the assessment centre, his behaviour must have regressed and he was discharged.

At home, co-operation between Social Service Officers eventually led to Q. attending an unusual type of Day Occupation Therapy Unit, where among a group of adults with a variety of handicaps, were some people hopefully recovering from mental illness. Here Q. received sympathetic treatment and considerable personal attention but he was also required to carry out fairly long spells of repetitive assembly and packing tasks, which he did quite well. I saw evidence of these facts when I visited the Unit when Q. was aged 21. I also visited him at his home and gained the impression that, although he showed some behaviour oddities, he had matured considerably. He has profited from mobility training in the neighbourhood of his home and he walks independently to the local pub and attends village football and cricket matches. He is particularly keen on the cricket club of which he is a member, sometimes accompanying the team on away matches. I saw a braille copy of a lengthy essay of, say, 2,000 words which Q. had presented to the tutor of a W.E.A. class which he was attending where economics and politics were subjects being studied. Friends had made a typed copy of the braille for the tutor's benefit.

I was not surprised to hear, eighteen months after my visit, that Q. was having a trial at a Sheltered Workshop for the Blind, where for four nights per week he was resident in an associated hostel, returning home for week-ends. Unfortunately he did not succeed in the trial and the persistent and imaginative help accorded Q. by a collection of people has received a set-back. Q.'s account of his failure is that he just couldn't manage the card-board box making job to which he was assigned. The manager of the workshop from whom I enquired what had happened, wrote that temperamentally he didn't fit in with other workers because of his self-assertive manner. Q. has now been at home for six months. He says Social Workers are looking for another job for him and in the autumn of 1974 he hopes to take some training in typewriting at the local College of Further Education. He seems to have survived the disappointment of the failure of the work placement without undue distress and there seems no need to consider him as having a very severe behaviour handicap (M).

Mr. C.U. has had a long history of behaviour disorders. He came to Condover at age eight and a half where his uncontrolled exploration and interfering with plumbing and electrical services caused near havoc and some danger to himself. At age 10 he had nine months residence in Maudesly Hospital for psychiatric treatment. There was no improvement on his return to school and after one month he was discharged and was admitted to a Rudolf Steiner School. With a short interval

between two periods there he left at age 17. Various attempts have been made to help C. — and his widowed mother with whom he lives. He has had two spells of rehabilitation at an R.N.I.B. rehabilitation centre, and when I saw him, he was awaiting a third. He spent a month's trial at a home for the blind where C. claims that he was not a problem to the staff, but at the end of the period he was not retained and no report or explanation was given.

Mr. C.U. reveals his intelligence in conversation. He is amazingly good in mobility. He retains his interest in electrical matters and some of this is rational, but, in his attempts to get some "free" electricity in his bedroom, he broke into the mains below the floor boards, blew out all the fuses and must have just missed electrocuting himself. Some quotes from my interview notes will show the difficulties of Mr. C.U. and his mother. "C. claims to be ashamed of what he calls his vandalism. Mother made it forcibly clear in his presence that the damage was costly and she re-iterated that you (her son) are intelligent and must, therefore, be able to control it. C. has consulted a psychiatrist apparently at the suggestion of the Social Services Officer who strives to give all the help he can. C. is said to have had an epileptic fit last year which the doctor is supposed to have attributed to having smoked heavily before breakfast. This led to an onslaught by Mrs. U. and her daughter to prevent C. smoking, a battle which was lost, though he now retires to the toilet to smoke." I finish with my final note which was, "Although I feel pessimistic about C. achieving any marked improvement or even achieving much modification of behaviour, I think it will be impossible while he continues to live at home." To which I add — where can C. go and where could he be occupied? His Social Worker seems to be trying every possibility.

Mr. E.D. has a very severe behaviour handicap (M). The behaviour difficulty seems intractable and E. appears to have been a misfit everywhere except in his family where he was the only child. Even at home he poses problems although the family life is planned around him as its centre. It would be easy to state that the excessive care which he has always received at home has caused E.'s behaviour handicap, but I think that this would be unfair. Father and mother were faced with severe problems when their blind child, who appeared to be intelligent and had this intelligence confirmed in intelligence tests, failed to make the progress at school which would have been expected. The educational failure was accompanied by strange conversation, "bad" language and very strange bodily mannerisms all of which were considerable social embarrassments, but the parents did their best to cope. E. was admitted to Condover at age 11½ after having failed in two other schools and he stayed until age 16. He revealed his intelligence only in the learning of braille, some progress in music, interest in some series of oral lessons and a certain strange facility in acquiring, mainly through a remarkable memory, a fairly lengthy series of phrases in several foreign languages. Otherwise he was unco-operative, obsessive in speech and behaviour and his intense mannerisms did not respond to any attempts at eradication, which varied from the forcible to the "psychological". In fact we had very little success with E. and he left school still with the severe behaviour handicap.

In my research survey I carried out four interviews concerning Mr. E.D.:-

(a) with E. himself and, although he was fairly rational in general conversation, he shied away from any attempts to discuss his own situation;

(b) with a Social Worker who has known E. and his parents for many years and feels that she is failing with them all. Also she considered that a disastrous attempt at an assessment at a rehabilitation centre should never have been undertaken and that his occasional attendance at a Work Centre, where he does nothing, is a complete loss;

(c) with the Deputy Manager of the Work Centre, which E. attends occasionally, who considers that the members of the Centre should really work and he wants to see discipline and the maximum individual and group work output. He spoke disparagingly of Social Workers and their tendency to be "soft theorists". He considered E. worthless as a worker, complained about his mannerisms and spoke of how he had lectured him about the mannerisms, the need to work, and what E. would do when his parents die. E. has learned some work processes but will not continue them as repetitive work, deliberately spoils materials and then settles down to his mannerisms. Yet, with all this, the Deputy Manager said that he still hopes that some new job will suit E. and prove to be the "magic key" which will solve his problems;

(d) with his parents who tend to be very critical of the impersonal "them" for not solving their son's difficulties in the past and in the present. They recognise E.'s lack of practical ability but they have encouraged his intellectual interests. He has been to language classes, accompanied by his father, but, on failing the 'O' level examination, he gave up the classes. Also he made an encouraging start at learning to play the organ but this had to be abandoned as the teacher left the district. An illuminating remark, almost an aside, from father was, "E. can't stand television. If we put on anything except music, he goes up to his room or shuts himself in the toilet."

Summary

Eight people live elsewhere than in the parental home:- three in hostels with a little occasional day occupation; five in flats or lodgings with no formal occupation.

Fifty-eight people live in the parental home:- 18 have a little day occupation; 40 have none.

Therefore, for the total of 66, 21 have a little occupation and 45 have none. Of the last 45 it should be noted that five people, all of normal intelligence, have educational or social commitments of considerable interest.

In my assessment of personal situations I described 16 people as "special cases". For seven of these I find it impossible to see any solution of very difficult situations. I have redistributed the other nine among the headings below; two to hospital, five to begin to attend centres, and two for work/ occupation investigation.

My complete list of suggestions is:-

no need for change of present situation -	20;
need for employment -	4;
need for employment/occupation investigation -	9;
need to increase attendance at centres -	10;
need to begin attendance at centres -	14;
needs admission to hospital -	2;
unresolved special cases -	7.

Leisure Time

Before proceeding to some general comments on leisure time, I will first consider two special topics with which I have been dealing continuously from Chapters 4 to 7 inclusive.

(1) Mobility

I have information concerning 62 of the 66 people in this chapter. People were asked to report on their independent mobility in the use of transport, long distance and local, and in walking, i.e. at least two miles or shorter walks in the neighbourhood of home. The results of this enquiry are expressed by allocating people to one of seven categories:-

(i) Fifteen people were excluded from consideration because of the severity of their physical handicaps. One of these people, however, uses a taxi and another travels widely with a variety of friends.

(ii) Seventeen people without physical handicaps never go outside home independently:- five PB; 12 blind.

(iii) Eight people take neighbourhood walks but do not use public transport:- three PS, one with physical handicap (a) and one with (b); three PB; two blind, one with physical handicap (a).

(iv) One PS takes long walks but does not use public transport.

(v) Six people use local transport and take neighbourhood walks:- one PS; one PB, with physical handicap (a); four blind, one having physical handicap (a).

(vi) Nine use local transport and take long walks:- four PS; three PB; two blind.

(vii) Six people use long distance transport and take long walks:- one PS; two PB; three blind, all three being guide dog owners.

Mobility Aids

Apart from the three guide dog owners, the 44 people who are mobile, at least to some extent outside home, use either the long cane, the short cane, or no aid, thus:-

Six long canes:- the physically handicapped blind person and one PB person in category (iii); three blind people included the physically handicapped person in category (v); one PB person in (vii).

Eleven no mobility aid:- no blind people; two PS and two PB in (iii); one PS in (iv); two PB and two PS in (vi); one PS in (vii).

Twenty-seven short canes, i.e. all people who have not already been indicated.

Comments

(1) Of the 17 "home-bound" people in category (ii), four blind and three PB were mobile in Condover village.

(2) No public transport training was given at school, because of the inconvenience and infrequency of the country 'bus service. Judging from the school record of mobility training, if the six people of category (v) have learned to use public transport, so could most of the people in (iii) and even some in (ii).

(3) The physically handicapped people who have achieved some mobility are a credit to themselves and whoever trained them.

(2) Literacy

I have information concerning 57 of the 66 ex-pupils. Of the missing nine, I know that five are illiterate and one reads and writes a little "sighted". The other three learned some braille, but I do not know the extent of their present use of it. The following statistics concern 57 people.

Braille Twelve are readers, in that they read at least the equivalent of six library books per year. All write some braille, including nine who make great use of it. Seven other people read some braille, though for two this is very little. All write a little braille also. Two people who read no braille, write occasional short letters.

Print There are no people who read print sufficiently to be classed as readers, comparable to the braille readers. Six do some reading, but for two this is only for headlines, simple notices, etc. Four do some writing but two do not.

Talking Book Twenty-four people use a talking book. For four of these the use is merely occasional, but 20 had read a minimum of six books in the year before the questionnaire was completed.

Comments

(1) The proportion of talking book users is higher than that found in other chapters. This is due to the high number of people with no intellectual handicap or a moderate handicap who have no organised day-time occupation.

(2) Considering illiteracy in its normal meaning of no reading or writing, 30 of the 57 people are completely illiterate. Of the 20 frequent listeners to the talking book, 11 can read neither braille nor print. If these 11 people were admitted to the ranks of the literate, the number of illiterate would be reduced to 19.

Information on Leisure Activities from Personal Questionnaires

Preliminary General Enquiry

I was interested to see if there were any significant differences in the use of leisure time between the two groups of ex-pupils who still live in the parental home, i.e. the people discussed in the present chapter, who have little or no attendance at Day Centres, and the people of Chapter 5, who attend centres five days per week. To keep in mind this difference I shall refer to these two groups as Group 7 and Group 5, the effective totals for the present enquiry being:-

Group 7:- N=52, i.e. the 66 people under discussion in this chapter, less eight people not living at home, less six people who did not return the questionnaire;

Group 5:- N=76, i.e. the 87 people discussed in Chapter 5, less 10 people not living at home, less one person who did not return the questionnaire.

I had one general hypothesis:- since Group 7 people have so much unorganised time they would be less satisfied with their leisure activities than Group 5 people who have plenty to do in "working hours".

The introductory question in the personal questionnaire, which was used throughout the whole research, was helpful in examining this hypothesis. It asked subjects to select the response appropriate to them from the following three:-

I am satisfied with things as they are;
While I am fairly satisfied, I would like a few more things to do;
I am often bored and would like a lot more to do in my spare time.

The responses to this general question were:-

Group 7:- satisfied - 27 (52%); fairly satisfied - 10 (19%); not satisfied - 11 (21%); no response - 4 (8%). N=52.

Group 5:- satisfied - 26 (34%); fairly satisfied - 25 (33%); not satisfied - 15 (20%); no response - 10 (13%). N=76.

Comments

More people of Group 7 than those of Group 5 are satisfied with their leisure time while the proportion of bored is almost identical in both groups. My general hypothesis is not supported by the responses to the questionnaire.

Activities at Home

Literacy has already been discussed, but I also enquired about the frequency of use of six other activities. The results are summarised in Table 7.VII, where the number for Group 7 remains at 52, but the number for Group 5 is reduced to 75, since one person who answered the introductory questions gave no other answers.

The total of 127 comprises 94% of the 135 ex-pupils who still live in their parental home. (I exclude those people who are employed, as described in Chapter 4.)

Table 7.VII Frequency of Leisure Activities at Home. (N=52+75=127)

	Never	Occasionally	2/3 per week	Most Days	No Answer	Total
Television						
7 N=52	7	18	4	22	1	127
5 N=75	13	28	5	28	1	
Radio						
7 N=52	1	4	4	43	0	127
5 N=75	2	4	6	62	1	
Record Listening						
7 N=52	6	22	3	20	1	127
5 N=75	7	25	11	31	1	
Tape-recording						
7 N=52	28	14	2	8	0	127
5 N=75	51	14	4	5	1	
Household Duties						
7 N=52	10	14	1	26	1	127
5 N=75	18	31	4	19	3	
Telephone						
7 N=52	23	17	0	10	2	127
5 N=75	29	33	4	7	2	

Comments

Television

I was surprised by the number of ex-pupils using television, though music is an obvious television interest even for blind people. I suspect that watching is largely conditioned by family circumstances and in some families the T.V. set is almost permanently switched on. I broke down the statistics for frequencies into the three groups of visually handicapped people thus:-

Visual Handicap	Never	Occasionally	2/3 Days per Week	Most Days
B (N=56)	11	16	3	26
PB (N=44)	8	18	4	14
PS (N=25)	1	12	2	10

Radio

The three people who never listen are deaf.

In an attempt to assess any elements of selected or planned listening, distinct from "global" listening, I asked people to list their favourite programmes. This exercise was a failure since many people made no entries under this heading, some gave general answers such as "most things", some listed as many as ten items and others only one. It was impossible to use the information in any meaningful way.

Records

No special comments.

Tape-recorder

For unpractical blind people and for many physically handicapped people the management of a tape-recorder is difficult.

Of the 47 people who use a tape-recorder, 45 own their machine, one borrows a machine while one person gave no information about ownership. The main use of the recorder by the ex-pupils is for recording music from records and broadcasts. Some specially interesting uses were:- correspondence: 3; family events: 3; recording outside events and noises, e.g. fairs, country sounds, brass band competitions: 3; aid to study: 2; knitting patterns: 1; learning to play clarinet: 1; learning hymns for choir: 1; and "for the art and interest of recording": 1.

Household Duties

Although most household chores were mentioned somewhere in the list, no one did any cooking or helping with it.

Ten of the people who never help are so severely handicapped that they could not do so. I was interested in the difference in the help offered, or expected, from men and women and I analysed the statistics with these results which concern 78 men and 45 women:-

never (N=28):- 22 men, six women; occasionally (N=45):- 35 men, ten women; 2/3 days per week (N=5):- four men, one woman; most days (N=45):- 17 men, 28 women.

Telephone

The frequency of use is obviously influenced by the presence of a telephone in the house. Examination of information available gave these results:-

"most day" users (N=17):- 15 'phones at home, two not; 2/3 days per week (N=4):- two at home, two not; occasional users (N=50):- 32 at home, 18 not; never (N=52):- 13 at home, 39 not.

Twenty-three people use a public call box, including some who have a 'phone at home.

Activities Away from Home

Ex-pupils were asked to select the one statement from the following three:- "I do go", "I don't go but I would like to", or "I don't want to go", which best describes their situation with regard to six activities. The results are summarised in Table 7.VIII. The statistics concern the same people who gave the information compiled in Table 7.VII except that one person in Group 5 who replied to the questions about activities at home did not do so about activities away from home, reducing the total for Group 5 to 74.

Table 7.VIII Leisure Activities Away from Home. (N=52+74=126)

	Do Go	Would Like	Don't Want	No Answer	Total
Swimming					
7 N=52	6	7	34	5	126
5 N=74	25	21	22	6	
Clubs					
7 N=52	26	6	16	4	126
5 N=74	42	8	21	3	
Pubs					
7 N=52	20	2	28	2	126
5 N=74	39	7	26	2	
Dancing					
7 N=52	7	5	36	4	126
5 N=74	14	11	46	3	
Church					
7 N=52	24	5	19	4	126
5 N=74	29	9	33	3	
Concerts, etc.					
7 N=52	22	11	16	3	126
5 N=74	38	11	22	3	

Notes

(1) It is important to remember that there are great differences in handicaps, ability, temperament and personal interests among the people being discussed. Many people would gain little or nothing from leisure activities away from home. The large number of replies of "I don't want to go" is understandable.

(2) The replies of "I don't go, but would like to" are of interest and significance.

(3) Some supplementary questions were asked about frequency of attendance, comparisons, types of organisations, etc. Reference is made to these in the comments which follow.

Comments

Swimming

A heated swimming pool was provided at school in 1959 and swimming became a very popular activity. I should add that in 1963 a swimming bath was provided at Rushton and some of the youngest of the ex-pupils learned to swim there. For convenience I shall refer to them as having learned at Condover. There are great differences for a visually handicapped swimmer between the controlled conditions of a school swimming bath and the crowded noisy atmosphere of a public bath. Only a few partially sighted ex-pupils could be expected to manage without help in a public bath. Nevertheless it was hoped that many ex-pupils would find opportunities for swimming after they had left school. Since this seems to be an important activity I have analysed the information available to me in some detail.

Table 7.VIII shows that the proportion of people who go swimming in Group 5 is considerably greater than the proportion in Group 7. There are two reasons for this:-

(a) Some centres provide swimming classes as part of their general day-time programmes. Of the 25 people in Group 5 who go swimming, 11 take advantage of opportunities provided at their centres, four attend classes or swimming clubs for handicapped people elsewhere, eight are taken swimming by members of their families, one partially sighted man goes alone and the other person gave no information. Only six people in Group 7 go swimming:- two to swimming clubs for the handicapped and four go swimming with members of their families.

(b) On the average the people in Group 5 are younger than the people in Group 7 and therefore a larger proportion were at school after the opening of the bath in 1959. Two criteria defining the possibility of an ex-pupil having learned to swim at school are:- leaving school in 1961 or later and spending at least two years at school. For Group 5 the number of ex-pupils fulfilling these conditions is 51 out of the total of 74. Comparative figures for Group 7 are 23 ex-pupils out of the total of 52.

I add some further information:-

Group 5 Of the 25 people who have opportunities to attend swimming classes, 20 can swim; 13 of the 21 who would like to go to swimming classes etc., can swim; of the 22 who do not wish to go swimming, five can swim. This gives a total of 38 swimmers, only three of whom learned to swim elsewhere than at Condover.

Group 7 All six people who attend swimming classes can swim; two of the seven people who would like to go swimming can swim; of the 34 who do not wish to go swimming, six can swim. Two people who gave no answer about their attendance at swimming can swim. This gives a total of 16 swimmers all of whom, except for two, learned the skill at Condover.

Comments

(1) Combining the statistics for both groups, it seems a great pity that the 28 people who would like to go swimming have not found an opportunity. Also it is possible that, with a little persuasion and the provision of comfortable conditions, the 11 swimmers who have abandoned the activity might be persuaded to take it up again.

(2) The statistics concerning the handicaps of the 54 swimmers are interesting and show that many quite severely multi-handicapped pupils learned to swim.

Visual Handicaps:-	PS - 10;	PB - 13;	B - 31.		
Intellectual Handicaps:-	Nil - 11;	A - 18;	B - 21;	C - 4.	
Physical Handicaps:-	Nil - 40;	a - 4;	b - 7;	c - 3.	
Behaviour Handicaps:-	Nil - 33;	m - 15;	M - 6.		
Deafness:-	Nil - 48;	d - 2;	D/B - 4.		
Epilepsy:-	No - 42;	Yes - 12.			

It should be noted that the 12 people rated as epileptic are either completely under control through medication or have infrequent, minor attacks.

In my comments on other activities, since there were no significant differences between Groups 5 and 7 I will deal with the statistics for both groups combined.

Clubs

Sixty-eight ex-pupils go to clubs, a few people attending more than one. The total of clubs mentioned by ex-pupils is 90, of which 69 are run on behalf of handicapped people by a variety of organisations:- staffs of centres, societies for different types of handicapped people, parents' organisations and churches. These clubs are mainly social gatherings and some outings are occasionally arranged. A usual length of time of a meeting is two hours and the frequency of meeting varies from weekly to monthly with an average of approximately one per fortnight. The club meetings are very much appreciated by the ex-pupils who are able to attend them. Fifteen ex-pupils attend clubs for non-handicapped people while six are members of branches of the organisation for Physically Handicapped and Able Bodied people, usually known as P.H.A.B. clubs. In these clubs the aim is to arrange for disabled people and the non-handicapped to meet on an equal footing for activities of mutual interest.

For the next four activities, the participation is largely determined by the general attitudes and practices of their respective families. For each activity it will be seen in Table 7.VIII that there is a small but important proportion of people who would like to take part but who have no opportunity to do so.

Pubs

Fifty-nine ex-pupils go to pubs. Seven people go alone, the others going either with members of their families or as part of club activities. Attendance is rather infrequent. Only three go more than once per week. Approximately half of the total go to a pub on special occasions only.

Dancing

Only 21 ex-pupils go to dances, but I did not expect that many would do so. Three go independently and four with friends, while the others go either with members with their families or to dances held at their clubs. Apart from three people who attend dances approximately once per week, attendance is infrequent.

Church

Of the 53 people who go to church, 27 are regular attenders, nearly always with their parents. One young man is very closely involved in church activities. Only one ex-pupil is a member of a church choir. An important feature of the school programme was the school choir. Many pupils could sing in tune and a

surprisingly large number of boys and girls could "hold a part" other than the main tune. Tunes and words had to be memorised but this was managed remarkably quickly. In a small church or chapel, with some simple help, quite a number of ex-pupils could become effective members of a choir.

Concerts and Theatres

Only one of the 60 ex-pupils who attend concerts, etc., can be described as an independent concert-goer. Otherwise people follow the family pattern or attend concerts at their clubs.

Additional Information

The Personal Questionnaire for ex-pupils had a section concerned with attendance at classes for study. Two physically handicapped ex-pupils of normal intelligence, as has been mentioned in the case descriptions earlier in this chapter, take further education seriously. Two other people attend Bible classes. It should be noted that a large number of ex-pupils attending A.T.C.'s take part in specially devised further education classes at their centres.

The final paragraph of the questionnaire asked ex-pupils to list any activities in which they were involved which had not been included in the main sections of the form. There were only a few responses to this request. Two young men attend football matches with their fathers. Two people play dominoes, one being a member of a league team. One man plays the piano for socials in a club for blind people. One woman helps with a Cub Pack. One man enjoys camping.

Summary

Bearing in mind the very serious handicaps of many of the ex-pupils and their consequent low level of ability and their lack of desire for further activities, the general leisure time situation could be considered to be reasonably satisfactory. Nevertheless I am left with the impression that for quite a number of ex-pupils living in their parents' homes, especially for those with no intellectual handicap or with only a moderate handicap, more could be done to help them. Too much is left to the parents and other members of the family. More contacts with people outside the family seems advisable, either with organisations or individuals — or both. I am thinking of quite simple things such as occasional invitations to tea or supper, walks, shopping expeditions, attendance at concerts etc., not only professional performances but local, amateur events. To achieve such contacts in some areas it may simply mean making needs known to local Community Service Organisations, Citizens' Advice Bureaus or Social Services Departments.

Topics from Parents' Questionnaires

There are two topics arising from the Parents' Questionnaire which are relevant to the discussion of Independence and Dependence to which I shall shortly turn.

(1) The Use of Money and the Understanding of its Value

Two related sections concerning financial matters were contained in the Parents' Questionnaire:-

(a) To find out how ex-pupils are treated with regard to their weekly income from Social Security and/or earnings, parents were asked to choose from the following four statements the one which seems nearest the truth:-

(i) Does X receive all his/her Social Security payments and/or earnings personally, pay you a certain amount and manage the rest independently like an unhandicapped son/daughter?
(ii) Do you keep all his/her money and pay him/her a fixed pocket money allowance which he/she manages independently or nearly so?
(iii) Do you keep all his/her money and pay him/her pocket money for special purposes as he/she needs it?
(iv) Do you keep all his/her money, simply making sure that he/she gets everything he/she needs?

(b) Parents were asked to choose from the following six statements concerning ex-pupils' use and understanding of money the one which seems nearest to the truth:-

Does he/she:-
(i) manage as well as you do?
(ii) need only a little help even with large sums?
(iii) manage up to £3.00 or £4.00 without help?
(iv) deal independently with values up to £1.00 only?
(v) deal independently with a few coins only?
(vi) have no real understanding of money at all?

The statistics for sections (a) and (b) are summarised in Table 7.IX, in which I revert to the use of the separate Groups 7 and 5, for which I have replies concerning 51 and 73 people respectively.

Table 7.IX Pocket Money Method and Understanding of Money. (N=51+73)

Allowance	Group 7	Group 5	Total	Understanding	Group 7	Group 5	Total
Independent	14	7	21	Independent	16	10	26
Fixed pocket money	17	26	43	Large sums	8	5	13
Occasional pockey money	4	12	16	Up to £3/£4	4	11	15
Parent controlled	14	27	41	Up to £1 only	7	7	14
No Answer	2	1	3	Few coins only	10	16	26
				No understanding	4	23	27
				No Answer	2	1	3
Totals	51	73	124		51	73	124

Comments

(1) The ex-pupils in Group 7 have a larger proportion of individuals with no intellectual handicap or with only a moderate handicap (A) than those in Group 5.

(2) The teaching of arithmetic was one of the most difficult educational problems at school. The staff devised, for the less intellectually able pupils, a variety of practical exercises in simple number which included classroom instruction and social experiences. Even for the most intellectually able, little written mathematics was possible. The practical use of money figured importantly in the school curriculum and included a graded, pocket-money scheme which arranged for individual pupils to handle frequently money that they could recognise and eventually count and understand. With approximately 25% of the pupils very little progress was made. They did not proceed further than the use of a few simple coins.

(3) It seems to me that from the point of view of boosting morale and for educational experience in the use of money, many more ex-pupils should feel responsible for their whole income or should have a fixed weekly pocket money allowance. I accept that for some ex-pupils, money is likely to remain a mystery and its physical handling presents great problems. However, as I compiled the statistics for Table 7.IX I made the following notes that, in my opinion:-

> of the 41 people whose income is completely administered by parents, 23 should receive a fixed pocket money allowance appropriate to their understanding of money; six should have some handling of their whole income;
>
> of the 16 who receive occasional pocket money, ten should receive a fixed amount; four should have some handling of their whole income;
>
> of the 43 people receiving fixed pocket money, 16 should have some handling of their whole income.

Suggestions for Parents (For convenience I mention sons only, but what I say is applicable to daughters too.)

If your son is independently mobile enough to visit the appropriate post office, let him collect his Social Security allowance himself. If he can get to the post office, but needs a guide, let him collect the allowance in the post office himself. If attendance at the office is impracticable for your son let whoever fetches the allowance give it to him first, even if he hands it over again shortly afterwards.

If it is at all possible, even if he needs some supervision and education at first, charge him an appropriate amount for board and lodging and, possibly, clothing, and let him have control of the rest. If it is more appropriate, fix a definite pocket money allowance. (As one indication, I point out that, if your son were resident in a hostel, his Social Security allowance would be paid to the Authority who runs the hostel, but the Authority would be required, by law, to make him a weekly pocket money allowance of £2.00.)

If your son cannot manage sums as large as £2.00, choose a lower sum, but treat this as an educational exercise, using the prospect of an increase in pocket money as an incentive to him to deal effectively with his money.

Give him the feeling that, however handicapped he may be, he is paying his way at home.

(2) Self-care Skills

I asked parents to score their sons and daughters on a five-point scale ranging from 'completely independent' to 'completely dependent' in the following aspects of self-care:- dressing, washing and bathing, personal appearance, eating, and toilet. The average ratings, after totalling the scores for the separate items, are shown in Table 7.X. The parents of 51 ex-pupils in Group 7 and 73 ex-pupils in Group 5 completed this section of the questionnaire.

Table 7.X Self-care Skills. Parents and School Estimates. (N=51+73)

	Group 7	Group 5	Total
Completely independent	27 (24)	30 (35)	57 (59)
Nearly independent	8 (13)	14 (22)	22 (35)
Help with a few things	9 (6)	18 (9)	27 (15)
Frequent help needed	3 (2)	9 (5)	12 (7)
Completely dependent	3 (4)	0 (0)	3 (4)
No answer	1 (2)	2 (2)	3 (4)
Totals	51	73	124

Comments

As an approximate check on the parents' scores I compared them with the ex-pupils''scores in independence in self-care when they left school. These are the numbers in brackets. Accurate comparison was not possible and I can only record two personal opinions:- (a) in a few cases, ex-pupils have received a little too much help and their self-care skills have deteriorated a little; and (b) all the ex-pupils recorded as completely dependent or as needing frequent help are correctly defined.

Independence and Dependence

I am considering the topic of independence-dependence from the special point of view of the people under discussion in this chapter, but my remarks have also a more general application.

Independence is, of course, a vital matter for all handicapped people, but most are, to some extent, dependent on help from others. The obvious aim should be to develop the highest possible degree of independence and to reduce dependence. In hospitals patients are often referred to in terms of high dependency and low dependency. It is helpful to think of the topic as a continuum from dependence to independence. Thus, with the very severely handicapped the emphasis is on the reduction of severe dependence and the benefit includes a large element of reduction of stress on the people providing the care. With the more able handicapped people the emphasis lies more on the benefits to the handicapped person of gaining increased independent living.

Important factors are self-care in the personal skills of washing, eating, etc.; the care of clothes and personal property; the ability to perform household tasks; the management of money; the social skills of dealing with people; independent mobility; the satisfactory use of leisure time. All these topics were integrated into the school programme and were very much in my mind as I carried out my research survey. I became very much aware that progress in these abilities should continue into adulthood, but that sometimes opportunities for this development are missed or not provided. From school records, answers to questionnaires to ex-pupils and their parents, and through personal interviews, I have a number of useful indications of each person's level of independence-dependence.

Towards the end of my research I felt the need of some sort of independence/dependence scale which would have relevance to the type of living situation available for ex-pupils and for other handicapped people. I have, therefore, devised a five-point scale which, with its notes, provides a few guide-lines for possible training as well as assessment of levels of independence/dependence.

The person concerned:-

(1) Completely Independently

The scale is devised to cover all Condover ex-pupils, hence the inclusion of this advanced category which applies to a few of them only, mainly some of those at work. Only an exceptionally capable totally blind person could manage this level of independence. I would not rule out occasional neighbourly help, but I would exclude planned, official supervision. Of the 66 subjects of the present chapter and the 87 subjects of chapter 5, I only rate Mr. S.H. and Miss K.C. as living in this category. They live independently in flats and have done so for some years.

(2) In Lodgings or its Equivalent

By "equivalent" I have in mind two situations.

(a) The person might live in rented accommodation, being given occasional help or supervision, comparable to that received by Miss D.G. and Mr. O.Q..

(b) If the person lives in his parents' home it would mean treatment as an adult and not a child. The services provided by the parents would be those that a lodger would normally expect:- provision of meals and arrangements for laundry. It is expected that the handicapped person would have independent control of his own money, paying for his keep. Independence of leisure and purchase of clothes are also implied. It would be reasonable, however, to allow some help with those services which a good landlady would provide, e.g. mending clothes, help with correspondence etc. (Several people among those now under discussion are in this category of lodgings equivalent.)

(3) In a Hostel with only Minor Supervision

Under this heading I include, as an equivalent, people living in their parents' home who, although not able to manage at category (2), nevertheless have a fairly high degree of independence. I would expect them to be completely independent in self-care, or nearly so, to have some leisure time interests, to be able to go out alone or with friends other than members of the family, to give some effective help at home and to have some "working hours occupation". Although they might not be able to manage their finances completely, they should have an income to which they feel entitled, e.g. their Social Security allowance less deductions for board and lodgings, clothing, etc. They should not feel that they receive only parentally controlled pocket money.

(4) In a Hostel, but Needing Considerable Care

People of this category still living in their parents' home would probably need some help with several aspects of independence. They would be in the more severe categories of at least two handicaps. Nevertheless, they would have some skills in self-care and might be expected to help a little in family life.

(5) Almost Completely Dependently

This needs no explanation except to point out that, if they were not living in their parents' home, people in this category would need either hospital care or some residential facility where the staff can provide a very high level of care indeed.

One of the reasons for devising this scale was the fact that, in the Parents' Questionnaire, I posed this question to parents:- "If or when your son/daughter has to live away from home put an X against ONE of the following statements which you consider the most appropriate:-

he/she could live independently in lodgings or a hostel;
he/she could manage quite well in a hostel with a little supervision;
he/she would need a fair amount of supervision and help but might manage a hostel life;
he/she would need almost complete help and it might mean hospital treatment."

It will be seen that my categories two to five are equivalent to the four statements from which parents had to choose.

The parents of 116 ex-pupils (49 from this chapter, i.e. Group 7 and 67 from Group 5) assessed how their sons and daughters could live if they had to live away from home now. These assessments are shown in Table 7.XI below and are scored according to my Independence/Dependence scale. I also show two of my own assessments:- firstly of the category in which the ex-pupils are living now and, secondly, of their potential levels of functioning.

Table 7.XI Three Assessments of Independence Ratings. (N=49+67)

		5	4	3	2	1	Totals
Parents' estimate of independence level	Group 7	10	16	18	5	0	49
My assessment of present living situation	"	7	23	13	6	0	49
My assessment of individuals' potentials	"	6	18	15	10	0	49
Parents' estimate of independence level	Group 5	4	38	25	0	0	67
My assessment of present living situation	"	4	46	16	1	0	67
My assessment of individuals' potentials	"	3	30	32	2	0	67
Parents' estimate of independence level	5 plus 7	14	54	43	5	0	116
My assessment of present living situation	"	11	69	29	7	0	116
My assessment of individuals' potentials	"	9	48	47	12	0	116

Comments

Comparison of lines seven and eight shows that my assessment of ex-pupils' present situation with regard to independence tends to be lower than that of the parents. I think that the explanation of the difference is that the parents have not thought of independence in money matters and mobility as being as important as I consider them to be. Also parents are probably often unaware of the amount of help they give their sons and daughters

I suggest that, through practice and education in the elements of independence which I have been stressing, the improvements indicated by my estimate of potential are realistic objectives, not difficult to attain.

Further Information from Parents' Questionnaires

Parents were asked to supply opinions about possible future living conditions of ex-pupils. There were two sections.

(a) Parents were asked if they think their son or daughter should live away from home now permanently or occasionally, with the following results:-

Table 7.XII Need to Live Away from Home Now. (N=47+67)

	Permanently	Occasionally	Neither	Totals
Group 7	0	15	32	47
Group 5	5	25	37	67
Totals	5	40	69	114

Comments

(1) I was surprised to note only five parents considered that their offspring should live away from home permanently now. All the ex-pupils concerned are men: four pose problems of management but the other needs more independent living conditions.

(2) The need for occasional residence away from home for handicapped people is well known. It is a means of reducing the burden imposed on parents of continual caring and has some advantages for the handicapped person also.

(b) The second section was introduced by this preamble:- "I am interested in the problem which might arise when you die or can no longer cope with X. Put a tick against the one statement among the following which best describes your situation."

Table 7.XIII Arrangements for Future Domicile. (N=49+74)

	Group 7	Group 5	Total
Satisfactory arrangements have already been made within the family	9	7	16
Satisfactory arrangements have already been made within the Social Services	3	0	3
We think satisfactory arrangements could be made within the family	13	16	29
We think satisfactory arrangements could be made by Social Services	9	10	19
We are very worried about this problem which is urgent	2	12	14
We are fairly worred about the problem	10	22	32
It is too early to bother about it	3	7	10
Totals	49	74	123

Comments

(1) Satisfactory arrangements for future domicile have been made for only 19 people.

(2) Parents of 46 ex-pupils are very worried or fairly worried about the problem. From conversations with parents I would have expected that this number might have been higher. The number is high because of the scarcity of residential accommodation.

(3) Of the total of 46 people referred to in Comment (2), 34 are in Group 5 and only 12 in Group 7. I have examined my complete statistics for explanations of this difference but can only make two comments:-

(a) out of the 74 in Group 5 I would classify 44 as having a major multi-handicap and 30 as having a minor. Of the group of 34 "worried", 22 have a major multi-handicap, which is not very different from the overall proportion;

(b) out of the 74 in Group 5, 34 are classified as blind but among the 34 "worried" only nine are blind.

(4) Individual circumstances of home life, personal temperament which help make up the whole situation are more important — and more difficult to define — than enumeration of handicaps.

Brief Summary of Whole Chapter

The topics of occupation and employment have already been discussed in the summaries of Chapters 4 and 5. Further discussion occurs in Chapter 9.

The problem of domicile, together with parental, personal and community responsibility, is dealt with in Chapter 9.

Here I confine myself to six brief comments.

Occupation

(1) My summary of the situation has already been given on page 200.

(2) I point out again the large proportion of really blind people with no intellectual handicap or with handicap (A).

Leisure Time

(1) The general situation concerning use of leisure seems reasonably satisfactory, though I would like to see some increase in help to some families so that ex-pupils have more contacts outside the family.

(2) Ex-pupils' understanding and use of money presents problems. Some practical suggestions to parents are given on page 210.

(3) An independence/dependence scale, based on living conditions, is given on page 212.

(4) Parents of 123 ex-pupils answered the question about what would happen to their sons and daughters when they — the parents — could no longer cope. Parents of 46 ex-pupils expressed severe or moderate worry about this situation.

CHAPTER 8

DEAF-BLINDNESS

Author's Note

The topic of combined deafness and blindness is very complicated. I am conscious that my discussion of deaf-blindness is rather superficial, but full treatment of the problem would have needed a whole book instead of this rather short chapter. My personal training and experience have been with blind children and, until deaf-blind children were admitted to Condover, I had no knowledge of the education of deaf children. Any comments I make on deafness are those, therefore, of an interested amateur rather than an expert. In some countries, notably in the U.S.A., the education of deaf-blind children preceded development of work for other types of multi-handicapped blind children. In Britain the education of deaf-blind children was an addition to a broader programme for other multi-handicapped blind children. For this reason, I have always tended to treat deafness as one of the several other types of handicap which can occur extra to blindness. I have, however, decided to devote one chapter of this report to deaf-blindness; while recognising the difficulties of combined visual and hearing difficulties, my main aim has been to show deaf-blindness as one form of multiple handicap. As will be made clear in the chapter, with many children, their visual handicap is the least of their difficulties.

Review of the Contents of the Chapter

The chapter is divided into four sections:-

1. A short introduction is followed by a discussion of some aspects of deaf-blindness. This establishes the fact that the deaf-blind children of today are very different from a few successful "classical" deaf-blind of earlier days.

2. An account is given of the development of the teaching of deaf-blind children at Condover. A small experimental unit for four children has developed into the permanent department, known as Pathways, which caters for approximately 30 children.

3. A report is presented on the placement of 24 deaf-blind ex-pupils who form part of the complete Research Survey of 314 Condover ex-pupils.

4. The presentation, in adapted form, of the research report to the tri-ennial Conference of the Educators of Deaf-Blind children. The section finishes with an attempt to consider briefly the future of 255 known rubella-deaf-blind children of school age who form, possibly, approximately one half of the total of such children in Britain.

SECTION 1: Introduction and Discussion of Some Aspects of Deaf-Blindness

In 1951, two years after the opening of Condover Hall School for Blind children with Other Handicaps, the R.N.I.B. responded to demands for something to be done for the education of deaf-blind children. At the time there was very little information about children who could be considered to need specialised education because they were deaf and blind - about the actual number of children, the severity of their handicaps, etc. It was decided, therefore, to set up a small experimental unit and Miss Joan Shields was appointed as its head but first she spent a year at the Perkins School for the Blind, Watertown, Massachusetts. The Perkins School pioneered the education of deaf-blind children and has provided help on a world-wide scale for deaf-blind children. Teachers from many countries have been trained in the Perkins Department for the Training of Teachers of the Deaf-blind and have then developed educational services for the deaf-blind in their own countries.

Several countries, apart from the U.S.A., had developed their own independent units of this type of education, usually based on the needs of one individual deaf-blind child or of a small group of such children. In fact the early work at Perkins - and elsewhere in the States - had also developed on these lines. It so happens that, in Europe, I have come to know something of the work which has been undertaken in Sweden, Germany, France and Russia, but, no-doubt, such pioneer efforts have taken place elsewhere. In several countries there were reports of remarkable progress made by deaf-blind people, but it was not always clear if these people had acquired the double handicap at a very early age before they had achieved any method of communication. It is important to bear in mind that there is a great difference between these young children, who have to be helped to develop what can be best described as an artificial method of communication, and those older people who become deaf and blind after they have acquired natural speech and written communication and who need to continue this communication by maintaining as far as possible the skills they had already developed.

Development of Communication

As will become very evident later, there are great individual variations in deaf-blind children such as the age of onset of the handicaps, the severity of the impairment of vision and hearing, the level of intelligence etc. What I shall now say about deaf-blind children as an introduction should be recognised as a very broad generalisation.

Deaf-blind children become aware of persons and things in their environment. For some this is a very gradual process and the awareness stays at a very low level even in adulthood. Others recognise and remember a number of familiar people and objects as well as actions such as sitting, walking, eating etc., but they have no words to indicate their knowledge. They have acquired a kind of "inner language" and will often use spontaneous gestures, signs etc. or they will manipulate people to show what they mean by taking them to fetch some object. They also understand similar signs and gestures from other people.

Some children stay at this level and are unable to go on to the next stage which is the break-through to verbal communication. Fundamentally the children simply have to learn to spell, i.e. to realise that we represent things, actions etc., by collections of letters. This is simple enough to state, but in practice, its realisation is difficult enough to justify the use of the word "break-through". It is the gateway to the whole world of language.

The "Classical" Deaf-Blind

The situation with regard to the successful education of deaf-blind children up to about 1950 was dominated by a few people whom I think of as the "classical" deaf-blind. By this I mean people who became severely deaf and severely blind, if not totally so, at an early age before they had acquired language, but achieved considerable success in acquiring a method of communication. With the classical deaf-blind there was, at some stage, a break-through to a sophisticated method of communication which allowed a considerable amount of conversation as well as the development of reading and writing. Not surprisingly, these classical deaf-blind people had normal or superior intelligence. A common cause of their deaf-blindness was tubercular meningitis, a disease which, through improved medical treatment, was largely eradicated in the 1950's in the developed countries. As far as I know, none of these people was born deaf-blind, but had a period of up to two years of age, even a little more, during which they could either see or hear or do both. They had achieved some normal awareness of their environment. Some probably had acquired a little speech which was lost because of their severe illness. I have not heard of the successful education of a congenitally completely deaf-blind baby.

I have met three classical deaf-blind people. Two were Americans who had acquired good communication with the Tadoma method by which the deaf-blind person "reads" the speech of another person by placing his thumb lightly on the speaker's lips with the fingers spread along the cheek and under the jaw. The thumb interprets the speaker's consonants by feeling the lip movements while the fingers sense the vowels by vibration. The deaf-blind person develops his own speech through a careful training involving, eventually, the imitation of his teacher's voice with one hand on his own face and the other on his teacher's face. My initiation into the successful outcome of this training for one person came in 1953 when I met Miss Juanita Morgan while she was still a student in the deaf-blind department at Perkins. She was then a young adult and must have been attending the school for about 15 years, having been admitted there at age 6. Apart from one or two elderly people, she was the first deaf-blind person I had ever met and my communication with her was accompanied by a confused emotional experience with elements of wonder, elation, and a general inner turmoil. This emotional experience must have been felt by most people when they have had their first experience of talking with a Tadoma-trained deaf-blind person. Juanita's voice was a little artificial but very easily understood. The touch of her hand on my face was so gentle that it offered almost no hindrance to my talking. The second time I met her she accepted my invitation to coffee and doughnuts in a drugstore, where we carried on a fairly normal conversation.

Twelve years later I met Mr. Leonard Dowdy, another successfully Tadoma-trained deaf-blind person when he addressed an international conference of teachers of deaf-blind children. By this time I was much more blasé and I could watch other people feeling the emotional experience I had felt with Juanita.

The third classical deaf-blind person I met was a boy named François who figured prominently in a book by Paul Rémy "Les Mains Revêtues de Lumière", which described deaf-blind people at the institutions for the deaf at Poitiers and Larnay. An English translation of the book has the title "May Morning". I went to Poitiers expecting that Francois' progress under his teacher Frere Thomas would not have been as great as the author had graphically described, but found that teacher and pupil had really achieved a great deal. François' conversational medium was the French deaf-blind manual and he was a fluent user of braille. As an indication of his intellectual ability I can state that one evening I taught François, who was then aged 17, the English deaf-blind manual alphabet which is completely different from the French manual. The next morning we held a conversation in French using the English manual!

To return to the Tadoma method and Juanita: I suppose I was naive enough to expect that, in our British experimental unit, we should admit a few deaf-blind children with the educational possibilities of Juanita. To be fair to myself this optimism was tinged with some doubt, since the development of a high level of success by the Tadoma method was the result of years of slow development with episodes of frustration. The strict adherence to a set educational pattern included the curtailment of the spontaneous use of natural sign and gesture which would, it was felt, distract the children and hamper the development of the formalised method of communication. This rigorous discipline, and the self-discipline of the deaf-blind children which it implied, caused behaviour difficulties which led, in the cases of some children, to the decision that they were ineducable.

A Completely Changed Situation

A radical change in the causes of deaf-blindness in children has taken place from approximately 1955 onwards, and has produced children whose handicaps and abilities are very different from the classical deaf-blind.

Tubercular meningitis, the main cause of classical deaf-blindness, has been eradicated. Children with complete loss of hearing and vision but with normal intelligence are very rare. In fact I know of no such children in Britain now. It should be realised that the number of successful classical deaf-blind children throughout the world was very small. To my knowledge the total has not been estimated but I would be surprised if the number this century has exceeded 30.

From a medical point of view the two main causes of deaf-blindness in children nowadays are:-

(a) The effects of the rubella virus on the embryos in some mothers who contract german measles in the early stages of pregnancy.

(b) Improved medical care of babies and children which has saved the lives of many, among whom are a considerable number of handicapped children, including a few who have combined defects of vision and hearing.

The rubella infection is responsible for the great majority of the children now described as deaf-blind in the developed countries of the world. Successive epidemics in Britain have produced a total of approximately 400 children who are now of school age. The worst affected country is the U.S.A. where estimates of the number of deaf-blind children of school age in 1974 are of the order of 7,000.

The continued use of the label "deaf-blind" is inaccurate and confusing. The new generation of "deaf-blind" children would be better described as children with severe difficulties of communication associated with defects of vision and hearing and often with other handicaps including, for many children, severe intellectual impairment. For many children their defective vision is the least of their handicaps.

When the first rubella children were diagnosed as deaf-blind it was natural for parents and teachers to turn for inspiration and guidance to the educational methods which had helped the classical deaf-blind. The last 20 years have been a period of adjustment to the reality of a new situation, an adjustment which is not yet complete.

The rest of this chapter will illustrate the changing situation through the presentation of information about the development of the education of deaf-blind

children at Condover and an account of the present placement of 24 deaf-blind ex-pupils with some tentative discussion of the future for these multi-handicapped children and adults.

SECTION 2: Development of the Education of Deaf-Blind Children at Condover

An Experimental Unit at Condover

When Miss Shields began her study course at Perkins, the site of the experimental deaf-blind unit had not been selected. Its eventual placement at Condover was fortuitous and was mainly due to the availability there of some unoccupied, very well-constructed stable buildings which could be adapted at low cost. The decision was not taken on educational lines. I remember that I thought there was considerable force in the argument that, when the deaf-blind children began to communicate they would benefit from contacts and communication with more intelligent children than those at Condover. The fact that deaf-blind children are blind children with other handicaps was not the prime reason for siting the unit at Condover. As events have turned out, however, I feel sure that the choice was correct. Condover had been founded to help multi-handicapped children who did not fit into the national pattern of education of blind children at the time of its founding. We felt that there was a challenge to us to develop unusual methods of education and only to declare children to be ineducable after a long trial. This was probably a good atmosphere in which to place the new experimental unit for four children which was opened in 1952 and called High Windows. As I have emphasised earlier, we were to discover that the children to be admitted to the permanent department, which eventually superseded the experimental unit, were very different from the classical deaf-blind.

Among the children at the unit during its first years were some really deaf-blind children with severe handicaps of both sight and hearing. Unfortunately four of these proved to have severe additional behaviour handicaps - one died suddenly because of a cerebral attack; one proved to be uncontrollable and was transferred to a Rudolf Steiner Home; the third, a boy, who was admitted at age 3, had to be discharged six years later as ineducable; the fourth child, a girl, who was born both deaf and blind had no real behaviour problems, but made very little progress in any way. She was an orphan and was admitted at age one and a half and when, eight years later she was finally discharged, she was behaving at the level of a child approximately 12 months old. Both this girl and the boy previously mentioned are now adults in special care sections of Hospitals for the Severely Mentally Handicapped.

The staff must have been greatly disappointed that, in the pioneering days of the unit, they were presented with children with such severe problems. Fortunately for their morale, there were three much more able pupils who are now at work. Two were severely deaf and one was partially deaf. One of the severely deaf was nearly totally blind and the other two had a little vision. Information about all three is given in Chapter 4 where they are referred to as Miss E.F., Mr. K.Q., and Mr. E.C. (see pages 81 and 84-86).

Naturally, the problems of the type of communication and its teaching were of extreme importance during the early years of the unit. No formal statements about policy were made, but quite soon it was realised that the Tadoma system was not going to be useful for any of our pupils. Within three years the policy, pragmatically assumed rather than formally declared, was that it was important to establish any possible form of communication as a base. Gestures, signs, attempts at speech were permitted, the final objectives being conversation via the deaf-blind manual with the support of reading and writing, and some spoken speech if possible.

Fundamentally the deaf-blind manual is a simple adaptation of the finger manual employed by seeing deaf people. Letters in the manual code are written on the deaf-blind person's hand and he replies in this way, but for a sighted person's benefit he may write the letters on his own hand and these can be read visually. Mr. E.C., is the only Condover pupil resembling the classical deaf-blind, but he had a little sight until he was about eight years old. Approximately one year before this he suddently realised that a sign on his hand meant some person or thing. The staff at first used only initials. E. soon knew the alphabet and he wanted to know the names of literally hundreds of things, persons, actions etc. Thus the spelling of words developed quickly. E's case had all the elements of a "break-through" to language comparable to that of the classical deaf-blind. With other children the process had been slow and laborious and the vocabulary acquired has been very limited. Nevertheless their education has not been considered a failure if they have learned some social and practical skills.

Anyone who knows how to read, be they sighted or blind, can memorise the manual alphabet quite quickly - in say, 30 minutes. To acquire speed of writing the manual on a person's hand requires more time, but can be achieved fairly easily. The ability to read quickly what a deaf-blind person is "saying" using the manual is a much more difficult and time consuming operation. Nevertheless, Mr. E.C., as a boy in his early teens, would teach a school visitor the manual and, within a half an hour or so, some simple conversation was possible. With people who have become deaf-blind after they have acquired normal speech, conversation is not very difficult provided they are encouraged to maintain a good speaking voice. One can learn to speak to them on their hands but the more difficult matter of "reading" what is being "said" in the manual is avoided because the deaf-blind person replies in spoken language.

Pathways, the Permanent Department for Deaf-Blind Children

Apart from their efforts to educate deaf-blind children the staff of High Windows carried out the important task of assessment of other children reputed to be deaf and blind, but for whom no places were available in the small unit. In 1959 the R.N.I.B. opened, in the grounds of Condover Hall, a purpose built department for 16 deaf-blind children which is known as "Pathways". The few pupils at High Windows had been of two extreme types - the very successful and those who made very little progress - but they were fairly obviously deaf and blind, though some had some small amounts of vision and hearing. However, a new type of child began to appear at assessment and the number of these increased as an extended programme of assessment was carried out at Pathways. By 1960 the first "rubella" children, had reached school age. By 1966 the number of assessments carried out by Miss Shields and her staff had exceeded 200 and the majority of these were rubella children. Some of the youngest of these were born handicapped because of the epidemics of 1962 and 1963. By 1967 it had become evident that there was a national educational problem much greater than could be coped with in an educational department of the size of Pathways.

As Pathways was the only school with a programme for deaf-blind children, many applications for the admission of young children began to be received. It was decided that Pathways should only accept the children who seemed the most hopeful for educational success. The number of places was increased from 16 to 26 and, in addition, some of the children already in residence, who were making only very little progress, were discharged. Since the age range of children at Pathways is from 5 to 17 or 18 and since most children were admitted at the lower end of this age range, once the full complement had been admitted vacancies occurred rarely.

Earlier I stated that for many deaf-blind children nowadays their defective vision is their most important asset. As an example of this and as an addition to my earlier remarks on communication I add this:- at Pathways, Miss Shields and her staff have been using for five years the Paget-Gorman system of carefully planned signs which can help children to acquire quite complicated - and grammatically correct - pre-verbal language skills. The ultimate objective is that this systematic training, which is quite enjoyable and interesting for children, should lead to reading, writing and verbal conversational skills. The Paget-Gorman system is essentially a visual system devised initially for seeing deaf people. It requires the recognition of hand and finger shapes and signs and the movements of hands and arms. Its use at Pathways by nearly every child is an indication of the visual efficiency of the deaf-blind children there. Also relevant is the fact that, if all the children now at Pathways succeeded in learning to read and write, three at most would need to use braille.

A very full educational programme is provided at Pathways with much emphasis on practical and social education and the development of personal independence. During the pupil's last two or three years the education is biased towards what they may do after leaving school. In the last section of this chapter we shall see Miss Shields' estimates of how the present pupils would function when they leave school.

Severely Handicapped Children not at Pathways

A small Association of Parents of Deaf-Blind Children, which was formed in the late 1950's, has expanded to become the larger and very active National Association for Deaf-Blind and Rubella Children. A few of the first rubella children had defects of vision and hearing and it was natural to describe them as "deaf-blind". The parents of some of these children were pioneers, agitating for the education of deaf-blind children. They must have suffered a period of intense disappointment when they realised that the most publicised methods of education of deaf-blind children, based on the success of a few classical deaf-blind children, would not help their children. Gradually they began to understand and accept the severity of their children's multiple handicaps. By this time many more rubella children had been born and a considerable number had been assessed at Pathways as having a poor educational prognosis.

The Association, which has campaigned vigorously for a programme of care and education for multi-handicapped rubella, deaf-blind children, has seen its propaganda achieve some success and a series of small units has been opened in various places in the country. Now it has turned its attention to the future provisions for rubella children, the majority of whom are of primary school age. What facilities will be available for them when they become adolescents and adults? Some success has been achieved by the Association in that they have helped to establish preliminary joint consultation between Ministries and voluntary associations for the blind and also for the deaf to consider facilities for adolescent and young adult deaf blind people. I shall continue to discuss this topic in the final section of this chapter after having first presented my report on deaf-blind ex-pupils.

SECTION 3: The Research Report - 24 Deaf-Blind Ex-Pupils

My research survey of Condover former pupils includes a sub-group of 31 deaf-blind pupils who had left the school by the end of 1970 and I will now summarise the statistics concerning them. Two have died and I have classified 5 others as "untraced". Two of these, brothers, emigrated with their parents to South Africa; one has probably died; the other two are probably in hospital. This leaves the actual number of subjects for study at 24, all of whom I have visited.

Although I have prepared a special section of my report so that I can summarise the information about deaf-blind ex-pupils, I emphasise that I have considered them as part of the complete research survey of multi-handicapped ex-pupils of many types. To help to achieve this integrated approach I have given case descriptions of deaf-blind people, where appropriate, in the various chapters of the main body of the report.

Grades of Deafness

In the other chapters of this report the people who were educated at Pathways have been indicated in the statistics for deafness as D/B. In this special section on deaf-blind people I wish to give a more detailed estimate of individuals' hearing losses. The topic of severity of hearing loss is, however, very complicated and I can only present a layman's simplified assessment of the severity of the 24 deaf-blind people's hearing defects.

The first four paragraphs concern those children who were born deaf or who became deaf before they had learned to talk.

1. There are children who, under good conditions, can, with a hearing aid - or in a few cases where the hearing loss is small, without an aid - understand speech and thus develop their language, spoken and written, in a fairly natural way though some special educational help is needed. Such people are often described as "hard of hearing" or "partially deaf". I will use the term "hard of hearing" for these people, reserving "partially deaf" for people with a more severe hearing loss. If they are blind they cannot, of course, use the pictorial aids which are so much used with seeing deaf-people, but teachers of the blind are used to substituting other sensory materials for visual aids in many branches of education. In any case, many of the deaf-blind children with whom we deal can be described as partially sighted, rather than blind, and can make use of visual aids.

2. There are children who have a greater hearing loss and I will describe them as "partially deaf". They are normally able to hear music and appreciate rhythm. With a hearing aid and, sometimes, with special classroom apparatus, they can be helped to understand speech but this is a slow, less natural process than with people described as "hard of hearing". Many partially deaf children acquire language, though some will use the manual alphabet and/or gestures instead of the spoken language. Partially deaf pupils who have a visual handicap and some language normally use the deaf-blind manual rather than the deaf manual.

3. Then I come to the category of the most severely deaf. I am tempted to use the term "totally deaf" but I have heard experts arguing that no person is really deaf to all sounds since there is some awareness of intense vibrations. So I will use the simple term "deaf" to describe those children who appear to hear nothing in the normal range of sound or only hear such a very little that it is of no use for the development of speech naturally, even with a hearing aid. Sighted deaf people rely completely on lip-reading for receiving speech and some gifted people develop a good voice for expressing speech. Communication is often helped by the use of the deaf manual alphabet and what I can best describe as that system of signs and gestures which is the "traditional language of the deaf". I have already described the Tadoma method for the deaf-blind using lip feeling for reception of speech and the voice for expression. The deaf-blind manual is more easily learned and is more widely used, but instant communication with strangers is not possible as it is for those few who have mastered the Tadoma method. Elements of the Tadoma method are sometimes used to encourage the use of speech in some deaf-blind children. In my experience the speech is confined to words or short phrases, though this comparatively minor amount of speech can be very useful.

4. In the previous three paragraphs I have been writing about peripheral deafness which is caused by damage to the hearing apparatus outside the brain centres, i.e. the cochlea, the auditory nerve, etc. Now I come to the rather difficult subject of "central deafness". This term is used to describe the handicap of people who can obviously hear sound, but whose auditory brain centres are unable to codify, or interpret, the sounds of heard speech so that it becomes intelligible. Some children are born with central deafness or develop it in their very early days but the handicap can be acquired much later in life as a result of a stroke, a brain tumour, or an illness affecting the brain. With the children the diagnosis is fraught with difficulties since degrees of peripheral deafness are often also present and the development of language and communication is rarely possible.

5. I have already mentioned the importance of the maintenance of good speaking habits in people who go deaf after they have established good use of language. Where sight remains unimpaired the other main task is the learning of methods of the reception of speech by lip-reading signs or manual, but they can continue to read and write visually. For children who are already blind when they acquire deafness, not only must they maintain good speech and learn the deaf-blind manual, but they have to learn braille too. This acquired deafness concerns three Condover ex-pupils only. One child was born blind and gradually became hard of hearing, but now is fairly severely partially deaf and the second child, who was partially blind from a very early age, has had a very similar decline in hearing. The speaking voice of both is becoming less distinct. The blind person is efficient in the use of braille and the deaf-blind manual but needs help with her speech. The partially blind person, who made very little progress in braille and the manual at school is in urgent need of instruction in communication. The third person became deaf and partially blind suddenly as a result of illness but has become very proficient in the use of braille and in communication via voice and deaf-blind manual.

Placement and Handicaps

Table 8.I shows the present placements of the 24 deaf-blind people who are ex-pupils of Condover, together with indications of their handicaps. Discussion of handicaps is given in Chapter 2 with a summary at the end of the chapter. A copy of the summary is printed on the bookmarker. The categories for deafness which I have used in the main research have been replaced by the following:
HH - hard of hearing; PD - partially deaf; D - deaf; C - centrally deaf.

Table 8.I Handicaps and Placements of Deaf-blind Ex-pupils (N=24)

		Hospital (10)	Work (4)	A.T.C. (5)	Other (5)	Totals
Sex	M	3	2	2	2	9
	F	7	2	3	3	15
Vision	PS	1	1	4	3	9
	PB	2	2	0	1	5
	B	7	1	1	1	10
Intellectual Handicap	Nil	0	3	0	3	6
	A	0	1	1	2	4
	B	0	0	2	0	2
	C	10	0	2	0	12
Physical Handicap	Nil	7	4	4	4	19
	a	0	0	1	1	2
	b	3	0	0	0	3
	c	0	0	0	0	0
Behaviour Handicap	Nil	2	4	3	3	12
	m	3	0	1	1	5
	M	5	0	1	1	7
Hearing Handicap	HH	1	0	1	2	4
	PD	0	1	1	3	5
	D	3	3	1	0	7
	C	6	0	2	0	8
Epilepsy	-	1	0	0	0	1

Notes: Of the five people in the column "Other", four live at home with little or no formal occupation. The fifth is resident in a home for blind adults. Three of the 24 people are still of school age and are not listed in any other descriptive section of my research report. I give notes concerning them in Comments 3 and 4 below.

Comments on Table 8.I

(1) In Hospitals for the Severely Mentally Handicapped (in some countries this would be described as Institutional). The multiplicity and severity of the handicaps of the 10 people in hospital is obvious from the table and I consider that all of them need this type of care. Brief notes and two short case descriptions will be found in Chapter 3, pages 51-52. None of the 10 people has any effective communication.

(2) At Work Three of the workers, Miss E.F. and Messrs E.C. and K.Q. were the most able of the pupils in the experimental unit and are not typical of the deaf-blind children of today. Case descriptions are given in Chapter 4, pages 81 and 84 respectively. Miss K.D. is of special interest, however, for although she is one of the most able, her handicaps are typical of the new type of deaf-blind child. She is deaf, partially sighted, and has an intellectual handicap (A), but has developed very little formal communication. Her case description is given in Chapter 4, page 96.

(3) At Adult Training Centres for the Mentally Handicapped. There are references to Messrs D.C. and H.T. in Chapter 5, pages 122 and 130.

Miss Q.B. is deaf, partially sighted, has an intellectual handicap (B) and has no communication apart from rather primitive signs and gestures. No other person among the members of her centre has any defect of hearing or vision. Q. fits well into the centre and earns slightly above the average amount of pocket money. When I saw her she was ironing pillow cases, using a calendar. The superintendent and his staff have been rather worried about Q's lack of communication, thinking that they should be doing more to develop this and experiencing some inadequacies because of their lack of specialist knowledge. They seemed re-assured when I pointed out that Q. had spent four years at Pathways without making much progress towards achieving a method of communication. Q.'s parents are very pleased with their daughter's placement at the centre.

Two girls, Janet and Christine, who are still of school age, were discharged from Pathways and are now attending special schools for the mentally handicapped, nowadays referred to as E.S.N. Schools (S). They were discharged because of the large number of applications for admission to Pathways as a result of rubella epidemics, some of the new applicants seeming to be more suitable for education than Janet and Christine. At school leaving age both girls will move to local A.T.C.s so I have placed them among the five people in that category in Table 8.I. Both are partially sighted, are centrally deaf and have intellectual handicaps (C). One girl has no other handicaps, but the second girl has a behaviour handicap (M), though there are strong indications that its severity is decreasing. I have visited the parents of both as well as the schools which the girls attend. Janet and Christine are making good progress, much helped by two facts:- they live at home and attend a school where the staff have skills in educating mentally handicapped children. I see no reason why the girls should be transferred to a special unit for rubella/deaf-blind children even if it were available, which is not the case.

(4) Others Four of these five are at home with little or no organised occupation. Miss D.G. is the blind young lady whose hearing has slowly deteriorated. She is a potential worker and she lives in a two bed-roomed council house which has been rented to her by her Local Authority. More information will be found about Miss D.G. in Chapter 7, page 182.

The four other people in this section are not mentioned in detail in other chapters of the research report, so I give some information about them here.

Miss K.M., now aged 17, was promoted at age 11 to a school for the visually handicapped, because she was partially sighted and hard of hearing, with no other marked handicaps. She made reasonably good educational progress and was recommended for a vocational training in commercial subjects at the Royal Normal College. I had anticipated a successful training, but I have recently heard that K. refused this training and hopes, rather unrealistically, to find work with horses or dogs.

Miss K.S. lives at the Leatherhead Home for Blind people. She is partially sighted and partially deaf, has an intellectual handicap which I rate as (A) and her behaviour has presented such difficulties that I have scored her behaviour handicaps as (M). The behaviour problems are partly due to some rather natural frustrations but there are also irrational elements. Miss K.S. talks very quickly but is quite difficult to understand; she can hear a loud voice but often she does not understand what has been said - in fact at times she positively misunderstands. K. has always hoped for employment at a level beyond her abilities, her main desire being to work with handicapped children. After disappointments concerned with failure in vocational training and in finding work or occupation, she lived at home for a period with her widowed mother. Eventually she was admitted to Leatherhead where I have seen her twice at an interval of two and a half years. On the second occasion I was pleasantly surprised to find that she was more relaxed.

Though she still shows some frustration, her behaviour has improved and her handicap could well be rated now in the more acceptable category of (m), were it not for the uncomfortable feeling that she might, one day, become more irrational again.

Mr. H.E., now aged 22, is a potential worker, but the long period of five years without occupation, following a vocational assessment course which was only partially successful, is reducing the possibility of his achieving work success. He is partially sighted and hard of hearing but has no other marked handicaps. There is, however, some uncertain evidence that his sight, hearing and general health may be deteriorating. He lives with his parents who naturally are very worried about their son's future. He is very mobile but he had a severe accident, when, for no reason, he fell down a long flight of stone steps with which he was quite familiar. The Social Service Department and the specialist Placement Officers are aware of this young man's situation but no solution of his problem seems likely. There is no sheltered workshop in the neighbourhood nor is a suitable occupation centre available.

Mr. N.D. is the person to whom I referred at the end of paragraph 5 as being in need of help in developing and maintaining some sort of communication. He still uses his voice with some effect but it tends to be a monologue often completely irrelevant to the conversation around him. He is becoming increasingly unable to understand remarks addressed to him repeatedly in a very loud voice. He was once classified correctly as hard of hearing but now he is probably quite severely partially deaf. His parents in their struggle to maintain their son's oral conversation, ignored the use of the deaf-blind manual, but it seems to me that efforts are now urgently needed to use this method for maintaining D's reception of information together with efforts to maintain good speech for his expressive communication. I consider that Mr. D.N. has a moderate intellectual handicap (A), and, although he is not really crippled, I think that his hydrocephalus causes such uncertainties of movement that he should be classified as having a physical handicap of category (a). D. lives with his parents. He carries out simple tasks daily in the family shop for an hour or two and his family make great efforts to prevent their son from being isolated. Occasional rather ineffective help is available from a Social Services Officer. No occupation centre is available for the young man to have contacts with other people and for the reduction of the parents' tension.

SECTION 4: Lecture to International Conference

The fifth of a series of tri-ennial conferences of the education of deaf-blind children was held at Condover in July 1974. The conference was attended by 120 people, 50 from England and 70 from 18 other countries. The English contingent included Her Majesty's Inspectors of Special Education, senior officials of the Department of Health and Social Security, teachers from schools for the blind and schools for the deaf, representatives of the Parents' Association and of voluntary organisations for the deaf. The foreign delegates were, with two or three exceptions only, directly involved in the education of deaf-blind children, the majority of these children being of rubella type.

I had been asked to present a session on Preparation for Leaving School and the Provision of Community Services. A delegate from the Perkins School dealt with the Leaving School and I concentrated on Community Services. I will give a brief account of the presentation of my contribution to the conference.

24 Deaf-Blind Ex-Pupils among 314 Multi-handicapped Blind Ex-Pupils

I prepared Table 8.II., which compares the occupation placements and present domiciles of deaf-blind ex-pupils with the main body of ex-pupils who are the subjects of the whole research.

Notes: The sub-totals for Day Centres, Parents' Home and Hospitals are slightly different from the statistics in the chapters on these topics in the report. I have included in Table 8.II. the four ex-pupils who are still of school age, since three of them are deaf-blind. (The fourth is a girl in the terminal ward of a hospital.)

In the Domicile Column, the numbers in brackets indicate the living conditions of the deaf-blind subjects.

Table 8.II Deaf-blind Ex-pupils as Part of the Whole Research (N=24)

	Total Research Including D/B (314)	D/B Only (24)	Domicile
Open Employment	41	3	Married : 24 (0) Flats : 4 (1)
Sheltered Employment	14	1	Lodgings : 6 (0) Hostels : 4 (1)
Housewives	9	0	Parents : 26 (2)
Day Centres (A.T.C.) (Mental Handicaps)	62	5	Hostels : 6 (0) Parents : 5 (5)
Day Centres (Other Handicaps)	27	0	Hostels : 4 (0) Parents : 23 (0)
Parents' Home (Little or No Occupation)	67	4	Flats : 4 (1) Lodgings : 1 (0) Hostels : 3 (0) Parents : 59 (3)
Residential (Blind)	41	1	Resident : 41 (1)
Residential (Other)	11	0	Resident : 11 (0)
In Hospital	42	10	Resident : 42 (10)

After having given the audience an opportunity to grasp the general pattern of the table, I made four points:-

1. Most of the ex-pupils in employment, who are, of course, the less seriously handicapped, profited from the vocational assessment and work placement services available for blind school leavers generally.

2. Of the 314 ex-pupils, only 44 are in facilities specialising in the care of multi-handicapped blind people; three are in the only day centre for such people and 41 in the only three residential establishments dealing with them.

3. There are certainly no specialised facilities for the occupation and residential care of young deaf-blind adults. As far as the 24 people in my enquiry are concerned, their placements follow the same pattern of placements as the whole group of multi-handicapped ex-pupils.

4. This is a summarising comment. Although admitting the need for very special educational methods for deaf-blind children, I have always considered the deaf-blind to be one section of the wider group of multi-handicapped blind people. After carrying out the research survey I see the multi-handicapped blind as one section of the much wider group of multi-handicapped and seriously handicapped people generally.

Notes on the Position of Deaf Blind Ex-Pupils

I stated that my enquiries about the present situation of deaf-blind ex-pupils convinced me that, apart from the few people who have no occupation, they were well placed and I referred to evidence which I have given earlier in this chapter in Table 8.I. and the subsequent case notes.

I had invited a number of people to give personal opinions in appropriate places in the next part of the session, which was concerned with three types of placements.

Employment I was anxious not to fall into the trap of emphasising the success of the minority group of four people and leaving the impression that many other deaf-blind people could achieve comparable success. However, I thought I should give one example of the successful placement of a really deaf-blind person. The Works Manager of the factory where Mr. E.C. has worked for eight years was in attendance. He spoke of the way he had been "conned" by an enthusiastic Blind Persons' Resettlement Officer into allowing a trial employment for one blind person, and of his dismay when he realised that the young man was deaf, too. He gave way to the insistence of the B.P.R.O. and assured the audience that E. is a good worker, really earning his pay, and that he has had a good effect on the other employees, 20 of whom can use the deaf-blind manual effectively. The Manager had brought one of E.'s workmates to the conference and he, after considerable persuasion, spoke to us. The sincerity of his contribution was strengthened by his Black Country accent as he spoke of the way in which the workers had accepted E. normally, expecting him to "muck in". E. had to stand the usual leg-pulling of new employees, which included a first pay packet made up of washers instead of money.

The Day Centre System Adult Training Centres for the Mentally Handicapped are more well developed than day centres for other types of handicapped people. As well as simple work occupations, most A.T.C.s offer specially devised educational programmes which include social experiences and training. Where no other facilities are available many ex-pupils, who are not really mentally handicapped, have profited from attendance at A.T.C.s. A contribution to the conference was made by the mother of Mr. H.T., a deaf-blind man with minor physical handicaps, who is not mentally handicapped but has been admitted to an A.T.C. Mrs. T. said that, after preliminary misgivings, she has found that the A.T.C. placement for her son has proved very suitable. Mrs. T. voiced a protest about the high-handed way in which some senior Social Services Officials have acted. She also raised a very vital problem, expressing it thus: "All is reasonably well now, with my son attending the centre and having a fairly full leisure programme at home, but what will happen when my husband and I can no longer cope?"

Mr. E.C. and Mr. H.T. were both present at this session of the conference. Their behaviour and response were so natural and interesting that I was afraid that they would "steal the show" and that the needs of the more seriously handicapped people would be overshadowed. However, I need not have worried, because of what followed.

Hospitals for the Mentally Handicapped (In some countries this type of care would be described as Institutional Care.) Sometimes it is very difficult for parents to accept that their son or daughter needs hospital care. It seems obvious to me that many deaf-blind children, now, or later as adults, need this type of placement. In presenting this point of view, I was very much helped by Mrs N., the mother of a 22 year old ex-pupil who is now in hospital. Mrs. N. was very nervous and had decided that she must write down beforehand what she wanted to say.

In fact, I am pretty sure that she had learned it by heart. The natural way in which she described in simple and sincere words how she had gradually come to accept that her daughter would be best placed in a "mental" hospital was most moving. She felt that her daughter is happy there, while the strain of caring for her at home has disappeared. Her daughter's frequent visits home are now happy family occasions. The unaffected sincerity of Mrs. N., and, indeed, of the other "non-professional" contributors, brought into a conference of professionals a feeling of the reality and urgency of the problems under discussion.

A Glimpse into the Future This very tentative exercise in assessing future possibilities concluded my session.

A small number of 24 ex-pupils is no real indication of the urgency of the problems of the placement of future deaf-blind school leavers. Because of rubella epidemics in the 1950's and 1960's, particularly those of 1962-3, there are at least 250 deaf-blind children of school age in Britain and there might well be more than 400. The importance of this problem has prompted me to extend my enquiry to include an assessment of these children's needs when they leave school. With the help of Miss Shields and the Chairman of the Education Committee of the National Association for Rubella and Deaf-Blind children, I had assembled some statistics which I presented to the Conference. These figures concern children of school age.

Pathways: 30, including three who have left school since 1971.

Day Units: 130. These units contain children most of whom are approaching the end of primary school age. Their continued care at Secondary age has to be planned for, and beyond this, of course, lies placement at school leaving age.

Hospitals: 95.

This assessment had been very superficial and there is a need for further much more detailed enquiries into the number of deaf-blind children with an objective assessment of their vision, hearing and additional handicaps. There are certainly some more children at home and in hospital who have not been included in the total of 255 children enumerated above.

We had made an estimate of the eventual placement of the 255 children when they leave school. I had to admit that this estimate was based, in many cases, on very tenuous evidence, but I considered it was reasonable to present the figures as an indication of the severity of children's handicaps. I allocated the children into three groups:

Employment (open or sheltered): 38, i.e. 18 Pathways and 20 others.

Adult Training Centres: 64, i.e. 9 Pathways and 55 others.

Hospital Care: 153, i.e. 3 Pathways and 150 others.

Summary:

Two important factors in planning for the future is that the use of a vaccine against rubella and the ability to detect infection in pregnant mothers, with subsequent abortion operation, will almost certainly reduce the number of births of rubella babies to a very small number indeed. Therefore, the planning can be for a finite number and not for an unknown and possibly increasing number.

It seems certain also that the majority of existing rubella children are mentally handicapped.

If the problem involved Pathways type deaf-blind children I would have no hesitation in recommending as a solution the integrated placement of deaf-blind/ rubella school leavers in the national facilities for the handicapped people generally. With somewhat less certainty I suggest that this placement pattern would suit the whole number of rubella children and that specialised facilities are not advisable. If, as I suspect, it is found that most of the rubella children of school age have effective residual vision, then I would, without reservation, recommend the integrated placement. The national facilities to which I refer would provide the following services according to the severity of handicaps:

The most capable school-leavers would be helped to find employment, open or sheltered, by existing services for the blind, as has already happened with some Pathways ex-pupils.

The moderately severely handicapped would be integrated into the day centre system with its associated hostels. Most of these people would need the mentally handicapped service. The staff would need advice from experts who have training with blind, deaf or deaf-blind people and there would be close liaison between centres and hospitals.

The most seriously handicapped would be assimilated into hospitals for the mentally handicapped, where facilities would vary, according to individual needs, from complete care to hostel life within or outside the hospital environment. Expert advice would be available from appropriate people.

Unfortunately such a co-ordinated national scheme is far from having been realised. Not enough money is yet available from public funds. Voluntary efforts are still needed to pioneer new services which will supplement Local Authority programmes. I think that the national scheme which I have outlined should be borne in mind when any development of facilities for separate types of handicapped people proceeds. It would be unfortunate if the founding of segregated units for the autistics, the spina bifidas, the deaf-blind, etc., were carried out without consultation between voluntary organisations, government departments and local authorities. The energies and finance coming from different organisations should lead to the development of some joint facilities or extensions of existing facilities and should be co-ordinated within the national planning, which is largely based on Local Authorities.

With these matters in mind, I hope that I am not being too optimistic when I state that recent discussions, initiated by the National Association, concerning the provision of occupation and residence for deaf-blind adolescents and adults, appear promising.

For some time the Association has been working towards the founding of these facilities and there was a time when it seemed that the Association favoured some kind of segregated national provision. However, the Association's Annual Report for 1973-4 states that the feeling of members has moved towards Regional Residential Centres rather than one National Centre. Another interesting statement, which I quote, is "the general feeling being for family sized units using local and internal occupation facilities". "Internal" facilities means those developed within the units and, presumably, "local occupational facilities" implies Adult Training Centres. My research survey has shown that placements of a few deaf-blind ex-pupils in A.T.C.s have proved successful and I ask that, if some integration for occupation is contemplate, why not some integration for residence too?

In the same Annual Report I have noted the Association's successful efforts to establish co-operation with other voluntary bodies aimed to achieve concerted efforts towards setting up future facilities. In early 1974 the Department of

Health and Social Security consulted the Royal National Institute for the Deaf and the Royal National Institute for the Blind about possible residential accommodation for young deaf-blind adults. Subsequently, further discussions have taken place between other voluntary associations for the deaf and for the blind as well as the National Association. The time has come for another meeting with the Department's representatives though this meeting, which was planned as part of the discussion programme, has not yet materialised. It is interesting and encouraging to note that (in a circular dated November 1974 from the Department to Local Authority Social Services, which concerned forward planning) priority in projects involving capital expenditure is attached to homes for the younger physically handicapped adults (including the blind and deaf).

Recommendations:

1. It is urgent that a register should be compiled of all rubella/deaf-blind children of school-age and that assessments of these children's handicaps should be made. (A special officer appointed for this project might well complete it in a year, especially if help were available from officers of the R.N.I.B.'s Educational Advisory Service.)

2. Transfer of rubella children who are now in Day Units to E.S.N. (S) Schools should be considered when the children have reached secondary school age.

3. This is more of a suggestion than a recommendation and it is directed to the National Association. Would the Association consider a pilot scheme of attaching a "family-size" unit to a Local Authority Hostel which is associated with an A.T.C.

CHAPTER 9

SUMMARY, COMMENTS AND RECOMMENDATIONS

N.B. *It should be noted that I often use the term, 'multi-handicapped blind people' as a synonym for 'visually handicapped people with additional handicaps'. Where I wish to distinguish between people who are really blind and those who have defective but useful vision, I make this clear in the text.*

Review of Contents of Chapter

Instead of reprinting the comments and recommendations which have been printed in various chapters of the report, I discuss in this final chapter five topics of special importance. These topics cover the major part of the research, but I have added, at the end of this review, notes indicating the whereabouts in the report of other information which is presented there in summary form.

Section 1, on the education of multi-handicapped children, is divided into two parts. The first has special reference to Condover Hall School and the second is a review of future educational developments on a national scale, with a set of recommendations.

Section 2 concerns some points of interest on visual, physical and mental handicaps which have arisen from the research, with brief recommendations.

Section 3 concerns the domicile of handicapped adults. In several chapters of the report I have indicated that discussion of this topic would be deferred until this final chapter, when the topics of responsibility of parents, the community and the handicapped people themselves would also be considered. After consideration of these topics and a brief summary of some relevant information from the research, there follows a set of recommendations.

Section 4 concerns the role of charitable organisations, stressing the importance of combining charitable efforts within general community developments.

Section 5 emphasises the fundamental role of Social Services in the welfare of handicapped people and stresses the urgent need for more finance so that the already existing theoretical legal provisions can be completely realised in practical services and facilities. Two groups of recommendations end the chapter, the first concerning co-ordination of services for the handicapped generally and the second dealing with the special needs of the multi-handicapped blind.

For any readers who may be relying on this chapter for a review of the research as a whole, I add notes on the whereabouts in the main report of information which will supplement the discussions of this chapter.

Chapter 3: "People in Hospitals" pp 47-49;
"A Blind Unit within a Hospital" pp 63-66;
"Recommendations" p 68.

Chapter 4: "Improvements in Work and Occupation" pp 71-73;
"Summary and Recommendations" pp 104-106.

Chapter 5: "Mental Handicap" pp 110-111;
"Summary, Practical Suggestions and Recommendations" pp 146-151.

Chapter 6: "Commentary and Suggestions" pp 158-161 and pp 170-171.

Chapter 7: "Special Note on Blind People" p 192;
"Independence/Dependence" pp 211-215.

Chapter 8: "A Completely Changed Situation" pp 219-220;
"Glimpse into the Future" pp 230-232.

SECTION 1: The Education of Multi-handicapped Blind Children

Special Notes for Condover

In this section, although I am writing mainly about Condover, it should be remembered that the R.N.I.B., through its Nursery Schools and Rushton Hall, provides education for younger multi-handicapped blind children. Sometimes, therefore, when I refer to Condover, my remarks may be relevant to these other schools also.

When the research survey was first discussed it was suggested that, included in its findings, there might be some evaluation of the success of Condover's educational programmes. This has not proved feasible. There were no children with similar handicaps who did not attend Condover who could have been treated as a control group. Neither have there been any follow-up studies of ex-pupils of schools for "normal" blind children which might have provided some interesting comparisons.

I can give very little detailed advice to Condover staff about changes in curricula in the light of the performance of ex-pupils. My general impressions are that the majority of ex-pupils have, in the context of the severity of their handicaps, proved to be socially acceptable, ready to adapt themselves to circumstances, and to have developed a certain degree of personal responsibility. I infer that life for several years at Condover, with opportunities for self-expression, the participation in community life, and the possibility of developing self-discipline, have all helped in forming the pleasant personal traits which have been noted by many people.

Since I was so intimately involved with the development of Condover, I feel diffident about stating that its educational programme is proving successful, but there really does not appear to be any need to make changes in the curriculum, though I wish to draw the attention of the school staff to two topics.

(a) The development of pupils' personal independence has always been considered to be one of the school's main aims. I would recommend that even greater emphasis should be laid on this aspect of education, which includes personal self-care, household chores, leisure activities, ease of social behaviour, mobility and the development of the maximum possible self-responsibility in financial matters. I realise that the last of these topics presents great educational difficulties and constitutes a challenge to staff - to teachers in particular - to develop a specialised programme of "mathematics".

I would like to draw attention to the discussion on Independence/Dependence towards the end of Chapter 5, and also to the final section of the present chapter where I describe as a "continuum" the facilities which are available, or should become available, for handicapped adults. Even slight improvements in individual pupils' abilities in personal independence, could lead to their being placed higher in the continuum.

(b) However good the educational programme at Condover may be, there are important factors which impede its complete effectiveness and these are connected with the fact that the school is very distant from most pupils' homes. I was always aware that at Condover we were providing an education based on a rural area of Shropshire for pupils who were, on the whole, city children. Social education and training in independence could have been much improved if the staff had been able to contact parents easily. Through my visits to parents I have realised what a waste of time the School Report system has been - and I accept the blame for this myself. An occasional factual, really personally based letter concerning each pupil's successes and failures with suggestions for holiday activities, would have been so much better. I suggest to the staff that, now that the school has its own travelling Careers Officer and the R.N.I.B. has it Educational Advisory Service, they could devise a system of exchange of information between school and pupils' homes which could produce educational co-operation of practical value.

Possible Future Developments Nationally

There are three factors, involving changing circumstances, which seem certain to affect the future of Condover and the R.N.I.B.'s whole programme for multi-handicapped blind children, and, indeed, the pattern of education of multi-handicapped children generally.

(a) In the last 15 years there has been an increase in the number of multi-handicapped blind babies and a decrease in the number of blind babies with no additional handicaps. These two facts combined have meant that some less severely multi-handicapped blind children, who formerly would have been admitted to Condover, are now in the regional schools for normal blind children, while Condover admits more very seriously handicapped children than previously.

(b) In 1971 Local Authority Education Committees took over responsibility for the education of all children, even the most severely handicapped. Among these are some multi-handicapped blind children who are in hospitals and others who attend what were formerly Junior Training Centres for the Mentally Handicapped, but which are now known as Schools for the Educationally Subnormal (S). I have not found any official statistics concerning these children, but the total number, including rubella deaf-blind children, must be of the order of seven or eight hundred. (The uncertainty of the statistics is shown in "Better Services for the Mentally Handicapped" (1971) where, in paragraph 25, it quotes, from the Wessex Survey of severely mentally handicapped children in hospital, that one in 20 were blind and one in five had defects of vision or hearing. This seems to differentiate between blindness and visual handicap and, if the national population of child patients in hospital is taken to be 5,500 - which is as reliable as I can find - we get the very imprecise statement that about 275 are blind and 1,100 have either a visual or a hearing defect.)

(c) There is a growing tendency for some Local Education Authorities to retain in local day schools some handicapped children who would previously have attended residential schools at a considerable distance from their homes.

The Vernon Committee, which was set up in 1968 by the Department of Education and Science to consider the organisation of educational services for the visually handicapped, made its recommendations in a Report published in 1972. It envisaged the preparation of regional plans to be produced by committees of local education authorities, which would be co-ordinated into a national plan by the D.E.S. The national plan would be promoted and supervised by a national committee. After some delays the regional committees are being set up in 1975.

Although the Vernon Committee was mainly concerned with the needs of visually handicapped children who have no additional handicaps, it gave some consideration to the multi-handicapped, which is summed up in its Recommendation 5.74 (10) thus:- "A variety of special schools and units should be available for visually handicapped children with additional handicaps. Where such children are accommodated in special schools for the multiply handicapped, due attention and care must be given to their visual handicap." A number of comments and suggestions are given in more detail in paragraphs 569-571 of the Report.

The recommendations which I make below, which I compiled before re-consulting the Report, are mainly in line with its findings, though my suggestions include additions and modifications.

Recommendations

1. Parents of multi-handicapped blind children are urgently in need of advice and help as soon as possible after the birth of the children. Specialist help is available through the R.N.I.B.'s Education Advisory Service, which is particularl interested in pre-school counselling.

2. There is an urgent need to assemble reliable statistics concerning multi-handicapped blind children who are at home, in E.S.N. (S) schools and in hospitals, and who are not already receiving special educational treatment.

3. The range of residential schools for multi-handicapped blind children provided by the R.N.I.B. will continue to be needed even when other educational service are developed. The R.N.I.B., through its schools and their staffs and through its Educational Advisory Service, should provide, on a national scale, a service of assessment of children and of advice to staff for schools and units offering education for multi-handicapped blind children.

4. Special non-academic education programmes, with emphasis on social and practical education, should be provided for the less seriously multi-handicapped children who can profit from admission to schools for the blind and the visually handicapped.

5. Special consideration is needed for visually handicapped children who have severe physical handicaps but no intellectual handicaps. The needs of partially sighted children will be best met by attendance at a school for the physically handicapped. For blind children the problem is complex, since the physical handicap may hinder the learning of braille. The number of really blind, severely physically handicapped children is small, and, therefore, it is advisable that the education of this type of child should be the responsibility of the R.N.I.B. schools.

6. Most multi-handicapped children with visual handicaps are less able than those referred to in Recommendations 3 and 4. Some need hospital care and the others are in the range of ability of children who attend E.S.N. schools of type (S). A number of multi-handicapped blind children are already attending hospitals and the (S) type schools, and this should be recognised as an acceptable policy for the future, provided the services mentioned in Recommendation 3 are available.

7. Some less seriously multi-handicapped blind children may have employment potential although their achievements in literacy and academic education are low. After school leaving age, these young people should have a programme of vocational training adapted realistically to their non-academic abilities, the type of simple

employment they could manage and the jobs available in the neighbourhood of their eventual domicile. Practical social education towards adulthood should form an important part of the programme.

8. This is a suggestion for consideration rather than a recommendation. Let us examine a possible situation in which a large Local Authority, in an area of dense population, had decided to educate all its handicapped children locally, sending none away to residential special schools. An attractive possibility would be the creation of an educational centre with sections for all types of handicapped children, including the multi-handicapped, in a modified form of comprehensive school. While children with different handicaps could have instruction appropriate to their special needs, all children could probably attend some general courses and could certainly profit from a variety of educational facilities much wider than would be economically viable in a small school. Although education would be mainly on a day basis, a residential centre would be available for children needing long term care of this nature but the centre would give short term educational experiences of living in a residential community and opportunities for training in self-care, independence, etc. Further advantages of such a comprehensive centre would include short term or long term integration of some children into schools for non-handicapped children, the provisions of vocational training linked with employment or with occupation in day centres for adults, Further Education programmes, and easy liaison with parents and Social Services.

SECTION 2: Some Thoughts on Handicaps

In the Condover research there are three areas concerning handicaps which have given me a considerable amount of disquiet.

(a) Visual Handicaps Nowadays there is a policy to consider blind, partially blind and partially sighted children and adults as members of the wide group of the visually handicapped. For administrative and organisational reasons this is a reasonable development, but the problems of the totally blind (and those who are nearly so) are very different from the problems of many partially blind people and all the partially sighted. This is certainly true for the multi-handicapped people who were the subjects of the research survey. In all types of employment and occupation which have been discussed in the report, the performance of the blind has been, on the average, well below that of people with defective, but useful sight. This is due not only to the difficulties blindness causes to the individual but also to the restricted range of work suitable for the blind compared with that available for the visually handicapped with some vision. It should be noted that I continue to use the term "multi-handicapped blind" when I wish to indicate the whole range of visually handicapped people with additional handicaps.

Two disturbing interlinked features of my research have been the considerable lack of specialist blind welfare services, particularly simple mobility training, for individual blind ex-pupils and, also, the lack of specialist advice concerning visual handicaps available for the staffs of centres which, though dealing mainly with sighted handicapped people, admit small numbers of visually handicapped people, including some who are blind.

Recommendation Multi-handicapped blind adults, especially the younger ones, who do not attend centres for the blind, or for the blind and physically handicapped, should have the same good opportunities for specialised training which are provided in these centres.

(b) Combined Physical and Visual Handicaps with no Intellectual Handicaps

In the research survey there was a small group of 22 ex-pupils with this combination of handicaps. I wish to draw special attention to the problems of these people, whose situation is particularly difficult and extremely so when the visual handicap is total blindness, as is the case with 15 people. Sighted physically handicapped people can use vision in training for special types of employment and in general life conditions. Blind people with no physical handicaps compensate for their blindness through the use of touch in gaining manual dexterity. Life is obviously more difficult for physically handicapped blind people and, when such people are of normal intelligence they are much more aware of their frustrating situation than are people with an additional intellectual handicap.

Some of these ex-pupils have had the distressing experience of having been refused training by organisations for the blind because of their physical handicaps and by organisations for the physically handicapped because of their blindness. There is no simple solution for the problems of these people and, it must be admitted, for some people open or sheltered employment under normal conditions is impossible. The whole group needs help from compassionate people with ingenious ideas about employment for the more capable and worthwhile life situation for all.

Recommendation A small combined sub-committee of the R.N.I.B. and the Spastics Society should be formed to draw attention to the situation of these people and to initiate action on their behalf.

(c) Mental Handicap

For welfare purposes and the associated facilities, handicapped people are classified into two groups: the mentally handicapped and the physically handicapped, the latter group including the blind and the deaf as well as people suffering from crippling defects. An important feature of the dichotomy of the provisions is that of day centres: Adult Training Centres for the Mentally Handicapped and Other Day Centres for the other types of handicapped people.

Are the considerable number of people who have both physical and mental handicaps to be consigned to the physically handicapped group or the mentally handicapped? My interest has been centred on blind people who can be considered to have a mental handicap in addition, but arguments concerning them are relevant to deaf people and to crippled people who have mental handicaps also. Permeating any discussion of this topic is a fairly general, unfortunate, emotional attitude towards mental handicap, which has led sometimes towards a change in nomenclature involving 'labels' which might appear less offensive. The former terms of 'mentally defective', 'mentally deficient', 'idiot' and 'imbecile' were changed to 'subnormal' and 'severe subnormal'. Now the fashionable word is 'mental handicap'. To me the latest term is more acceptable than the former descriptions, though, whatever label is given to the handicap, its nature is not changed nor its effects minimised. In my research I used the terms 'intellectual handicap' and 'behaviour handicap' to describe ex-pupils' difficulties, but I did not intend these to replace 'mental handicap', and I will shortly make some statements concerning mental handicap in relation to ex-pupils.

The Mental Health Act (1959), in its definition of severe subnormality (severe mental handicap), combined the concept of severe subnormality of intelligence with the inability to live independently. Its definition of subnormality (mental handicap) combines the concept of subnormality of intelligence with the possibility of independent living. Behaviour difficulties which can constitute a mental handicap are called psychopathic disorders, and these can occur with, or without, subnormality of intelligence.

I have no hesitation in stating that a considerable number of Condover ex-pupils are mentally handicapped according to the definitions of the Act. There are, however, many multi-handicapped ex-pupils who have only a moderate intellectual handicap, which does not really amount to subnormality, but who are not able to achieve personal and economic independence and who are, in practical matters, very ineffective. These people present problems when their placement in the mentally handicapped category or the physically handicapped category, with consequent attendance at day centres, is being considered. The Act made no statements about the borderline measurements for distinguishing between severe subnormality of intelligence and subnormality, or between subnormality of intelligence and normal intelligence. In practice, many people use an I.Q. of 50 as the borderline between severe subnormality and subnormality but there is no accepted suggestion about a measure for the upper range of subnormality.

Recommendations

1. Ex-pupils with intellectual handicaps (C) and (B) according to my scale, should be treated as mentally handicapped, whether they have a behaviour handicap or not. I would only exclude a few people at the higher range of category (B) who have no behaviour handicap.

2. For the few people of handicap (B) referred to in paragraph 1, plus ex-pupils with less severe intellectual handicaps, no decision about mental handicap need be made. Where a choice exists between attendance at an A.T.C. and an Other Day Centre, personal abilities and circumstances, and the variety of activities offered by the centres, should be taken into account.

3. In small Local Authority areas consideration should be given to amalgamating the facilities for some mentally handicapped and some physically handicapped people. In larger areas, a centre intermediate between A.T.C.s and Other Day Centres should be included in the total provisions.

Note: For people who are sighted but have combined physical and mental handicaps, a simple adaptation of Suggestions 1 and 2 could be - "Wherever a mental handicap is very marked, a person should be classed as mentally handicapped. Otherwise, make no decision and allow a choice."

SECTION 3: Domicile and Responsibility

Although living conditions are only one part of the general services for the handicapped, I have detached this topic for special discussion because it seems to me to be a matter of the highest importance. There are three inter-linked areas of responsibility: that of the parents, of the handicapped people themselves and of the community.

(a) Parental Responsibility This varies according to the age of the handicapped child or adult and according to the severity of his handicaps.

Some babies are so grossly handicapped at birth that hospitalisation is needed at once. Progress is minimal and one wonders why some of them should not be allowed to die. Seriously and moderately handicapped babies are normally absorbed into family life with all the adjustments that this involves, e.g. specialised care of the child; the difficulty of achieving a balance between rational appreciation of the child's handicaps and the loving attention he needs; a feeling of the growing isolation of the family from normal social life, etc.

At school age, there are three broad possibilities. Firstly, for parents of the less seriously handicapped, there is the relief - even joy - of finding that

there is the certainty of a type of special education for their children which will parallel most of the features of normal education. Secondly, for parents of moderately handicapped children there is some relief - but not much joy! - at finding that education is available, but it is of a very special nature, often involving treatment of the children as very backward or "mental". Thirdly, for the parents of very seriously handicapped children, there can be great uncertainty and unhappiness about education which might mean a very restricted programme, some home tuition or the possibility of admission to a hospital which may still have the title, "for the severely subnormal".

At school leaving age, the situation of the three groups of parents can be summed up thus: the continued joy that less seriously handicapped children can have further education, vocational training and eventual placement into employment; relief, or resignation, that day centres are available so that occupation of some kind is possible for moderately handicapped adults, leaving the parents free from responsibility for care during the day time (though some parents will feel resentment because, in their neighbourhood, such facilities are not available); despair, or something near it, that for the most severely handicapped nothing is available except the choice between complete care at home or admission to hospital (if a place is available).

By this time a problem, which will have been in the minds of all parents, except those whose sons and daughters are well on the way to independent adulthood, will have become much more urgent:- what will happen to our children, who are fast becoming adults, when we die or can no longer cope with them?

Let us examine briefly this topic of parental responsibility. Should parents have to be responsible for their handicapped sons or daughters in the parental home until some crisis occurs which makes this impossible? Some parents make comfortable adjustments to family life and have assurances from relatives or from Social Service that, when the crisis comes, satisfactory arrangements will be made for the care of the handicapped people. Some parents find residential placement for their handicapped offspring, usually paid for by the Local Authority. Other parents would like to find such a solution of their difficulties, but have not succeeded in doing so. Of these parents, some may have feelings of guilt about the devolvement of responsibility or expense on to the community, or, even, about having "abandoned" responsibility for their sons and daughters. Other parents expect the service as a right to which they are entitled, citing one or more of the following reasons for residential placement:- the need of handicapped people for companionship with people of similar abilities and interests; the isolating effect on a handicapped person living in a small family; the restrictions imposed on the rest of the family by the continued presence of its handicapped member; the need for better care than the family can provide; the uncertainty of the future.

(b) Self-Responsibility of Handicapped People Much depends on the level of awareness, by the handicapped people themselves, of their own identity and their situation. At one end of the scale of awareness are the very seriously handicapped who have little or no consciousness of their circumstances and must remain completely dependent. At the other end of the scale are people of normal intelligence who are very conscious of their situation. They have handicaps which prevent them from becoming economically independent and which cause them, to some extent, to remain personally dependent. Nevertheless, some of these may have a wish - and, I think, a right - for a life apart from the parental home, in living conditions which give them responsibility, as adults, for some control of their affairs. Obviously there are many people who lie between these two extremes, some of whom may well have the right to take decisions about their life situations and a measure of independent living. This right of decision should be respected and, in appropriate cases, residential accommodation should be granted.

(c) Community Responsibility By this, I mean national acceptance of responsibility for the welfare of the handicapped with, in most instances, local and/or regional solutions of problems. This topic will be discussed further in the next, and final, section of the chapter. Here I confine myself to two important statements. The community should:

support the parents of handicapped adults, conceding them the right to shed some, or all, of their responsibilities when it becomes advisable, not having to await a crisis situation;

respect the right of those handicapped people who wish to take responsibility for their independent living and are able to do so, even if they need aid in some aspects of daily life, and help them to achieve their desires.

Part III of the National Assistance Act (1948) deals with accommodation and states that Local Authorities have a duty to provide residential accommodation "for people who from age, infirmity or any other circumstances are in need of accommodation not otherwise available to them". The statements (a) and (b) above imply a combination of "infirmity" and "any other circumstances" which should qualify the handicapped people concerned for the right to residential accommodation.

Up to this point, my discussion has been concerned with handicapped generally. I turn now briefly to consideration of multi-handicapped blind adults.

Some Information from the Research

(i) Seven of the ex-pupils in hospital are resident there for social, rather than medical, reasons, no alternative residential accommodation being available. Three have no parents and for the other four the hospital placement was a solution of present or future family crisis situations.

(ii) Sixty-three ex-pupils are in residential facilities of "home" or hostel type. Thirty-nine are in homes with a national catchment area (30 at Leatherhead and eight at Wilberforce, both places specialising with blind people; one person is in a home for the physically handicapped, not specialising with the blind). Twenty-four are in hostels serving local areas, only one hostel (with two ex-pupil residents) specialising with the Blind.

Of the total of 63 residents, 14 have no parents or near relatives, seven have very infrequent contact with parents or relatives; six have no parents but have interested relatives who maintain good contact.

Thirty-six have parents, who have not shelved their responsibilities, but have solved the residential problem which looms up seriously now that their offspring are no longer children. The parents keep in touch with their sons and daughters frequently, nearly all of them providing holidays at home. Some of the ex-pupils, in any case, welcome the semi-independence of living away from home.

(iii) One hundred and thirty-three of the ex-pupils who either attend day centres or who have little or no occupation still live in the parental home. I have statements from the parents of 114 of these pupils concerning the future domicile of their handicapped sons and daughters: Five would like their son or daughter to live away from home now, permanently. Forty would like their son or daughter to live away from home now, occasionally. If the rights which I stated in paragraphs (a) and (b) were generally accepted and well known, I have no doubt that the numbers I have just quoted would have been much higher, especially the number to live away from home now permanently.

(iv) In reply to my enquiries about the future domicile of ex-pupils when they would have to live away from home, 123 parents gave information:-

Sixteen had made arrangements within the family and 29 thought that they could do so; three had made arrangements with Social Services and 19 thought that they could do so; ten thought it was too early to bother about the problem; fourteen were very worried and 32 were fairly worried about the problem

Recommendations

It seems that I can best present a summary of the topic of domicile in the form of a series of recommendations. I wish to point out that most of these recommendations are based on my observation of those aspects of some facilities which are already in existence and which indicate good lines of development.

1. More residential facilities of all types should be provided. The need is very urgent.

2. Living in the parental home can often be a pleasant solution of the living situation of handicapped adults. There should, however, be no feeling of compulsion about this, and the alternative of living in an appropriate residential establishment should be available. Change from parental home to a residential facility should be possible whenever family circumstances make this change advisable.

3. The range of appropriate residential establishments should be from complete hospital care to near independent living in small flats. The major need is likely to remain the provision of hostels. (At least one Local Authority has provided a hostel, the staff of which also supervise and help physically handicapped adults living in houses in the nearby housing estate.)

4. The general climate of opinion about the type of hostel favours the provision of fairly small establishments in the range from 12 to 40 residents. These conditions make it possible to realise two objectives, which seem to me to be very important: the handicapped residents should take as much responsibility as possible for daily domestic routines and for the direction of the establishment generally.

5. Short stay residence is a very important amenity which should always be available. It can provide occasional family relief and can also be a planned educational experience for handicapped people aimed at improving independent living and as a preparation for eventual full-term residential life.

6. Many multi-handicapped blind adults would profit from living in hostels for sighted handicapped people.

7. Voluntary organisations may well be able to help in the provision of residential facilities as an addition to, but in co-operation with, Local Authority efforts.

SECTION 4: The Role of Charitable Organisations and Voluntary Service

Historically, most developments in the education and welfare of handicapped people began with charitably minded individuals and organisations. Some pioneer work for the welfare of blind people began as long as 200 years ago, whereas the Spastics Society began its work only about 30 years ago. The pattern of the development of projects initiated by private efforts is that there is a gradual take-over by public bodies, usually Local Authorities. The Local Authority may take complete charge, or charitable organisations may contine to administer

Schools, Homes, etc., devoting some of their private finance to the running costs but deriving most of their income from fees paid by Local Authorities. The latter method is very common with regard to schools for handicapped children and is used also by Homes like the Wilberforce and Leatherhead "School" institutions. One interesting, fairly recent, development has been the building in Durham of a hostel by the Spastics Society and its subsequent handing over to the Local Authority.

Ideally one could hope that a civilised community like Britain would now be able to finance all new capital developments and the running costs of a co-ordinated national service from public funds. Charitable organisations and Voluntary Service schemes, churches, etc., could then concentrate on the important tasks of providing friendship and personal service to handicapped people, helping them to be assimilated as far as possible into community life. This ideal situation has not yet been attained, though, as I point out later, it could probably be achieved through co-ordinated, vigorous community efforts. Financial aid from voluntary efforts is still needed, especially in capital expenditure for the provision of new facilities. However, it seems urgent to have some sort of control on the efforts of voluntary organisations so that the finance which can be gathered from money-raising efforts, which must have finite limits, is directed to areas of the greatest need. In the past there have been instances of the raising of vast sums of money for handicapped people of particular types where there was a great emotional appeal because of the nature of the handicap, or where a fortunate advertising gimmick was found. More money than was really needed was collected, yet, according to the regulations of the Societies concerned, excess money could not be used for people of other types of handicaps, whose needs were equally great, but whose cases had not been publicised.

I think that tendencies towards some sort of equity already exist but I suggest the following recommendations:-

1. There should be co-operation between voluntary organisations to avoid over-emphasis on a particular type of handicap and to produce joint efforts for a broader range of handicaps.

2. There should be consultation between voluntary organisations and Social Services with a view to co-ordinating developments so that they fit into local planning.

3. An important area in which voluntary organisations could help is the provision of residential accommodation, especially in association with existing, or planned future, day centres.

(I draw attention to the relevance of the Housing Act (1974) with its suggestions for financial help for Housing Associations, which can be concerned with the setting up of hostels for handicapped people. The Birmingham Royal Institute for the Blind has already profited from the Act in planning a hostel for its Elizabeth Gunn Centre - see page 141 - and I am one member of the newly formed Housing Association. Through lack of funds, the B.R.I.B. was having to defer indefinitely its plans for a hostel, but now the project is likely to be realised quite soon. People interested in the possibility of setting up similar facilities should consult the Department of the Environment.)

SECTION 5: The Social Services

General Considerations

The Local Authority Social Services act (1970), which put into effect the recommendations of the Seebohm Report (1968), set up the Local Authority Social Service Departments to co-ordinate, and take responsibility for, all aspects of welfare: Child Care, Mental Welfare, Welfare of the Blind and of other types of handicapped people, and the Elderly, all of which had previously been administered by separate organisations.

When I began my research in 1971, the work of founding these new Social Services Departments was just beginning and I realised what a colossal task was being undertaken. Each of the services which was being assimilated had its own needs for improvement and extension of its services, but no extra finances were available to Social Services. The Government seemed to expect that the rationalisation and streamlining of the combined administration would achieve considerable savings which could be devoted to improvement of services. This was, of course, not true in practice. It was a pity that the re-organisation of the services was not accompanied by an injection of new finance so that the effects of the change could have been shown to have produced quick improvements in the circumstances of the "clients" served by the new regime. It is unfortunate that the first four years of the Social Services Departments have taken place in a period of national financial difficulties which, in 1975, have assumed crisis proportions. The enthusiasm of committees and officers, who must have hoped for great improvements in the country's welfare facilities, has been somewhat dulled by the financial stringencies accompanied by ever increasing demands for better and more extensive services. Social Service Committees and, in particular, their over-worked officers have been subjected to largely unjustified criticisms of defective services, when the real culprits were, in effect, all of us who, as members of the public, do not provide enough money.

The outlook, however, is not completely gloomy, since there are a few vaguely hopeful factors: Social Services people have retained most of their enthusiasm; improvements have been made in some directions, including a few which I have seen, for handicapped people; there have been many pronouncements recently (and I hope they will not prove to have been lip-service only) by political parties, trade unions etc., to the effect that, in these times of severe financial restrictions, the handicapped and the elderly should not suffer, but should receive priority of treatment. Before I leave the subject of general welfare, to return to the consideration of that fairly small area which is concerned with severely and multiply handicapped adults, I put forward two recommendations:

1. (This should be addressed to the general public on the lines of "You cannot have priority services for the handicapped and the elderly, and maintain all other services adequately and, at the same time, have reductions in rates and taxes".) Local Authority Social Services Committees should publicise in some detail their priority plans (which, in any case, they have to prepare for submission to the Department of Health and Social Security), with indications of the costs involved.

2. Local Authorities should discuss their plans with interested voluntary organisations and work out with them a co-ordinated scheme for action in their areas. A tactful, but vigorous, lead should be given by Social Services so that an accepted system of consultation and discussion is set up which could lead to complete care of the community's handicapped in a way calculated to invite and expect community participation.

Resonsibilities for Handicapped

A number of Acts of Parliament which have been enacted since 1944 are concerned with the welfare of handicapped people generally. There is no longer any Act dealing separately with blind people, the provisions of the former Blind Persons Acts having been incorporated into the general legislation for all handicapped people. The special needs of the blind are still recognised but their welfare arrangements are increasingly being incorporated with the provisions for other people.

Legislative Provisions - A National Plan

Three Acts form the fundamental basis of a remarkably comprehensive scheme covering almost all aspects of welfare for the handicapped. In my research survey I have been particularly interested in employment, occupation and facilities for the more severely handicapped section of the community, with special reference to the multi-handicapped blind. The country has, in theory, a legislative compulsion to provide what amounts to a continuum of services, though it arises from three separate Acts.

The Mental Health Act (1959) authorises:

(1) Hospital care for the Mentally Handicapped and for the Mentally ill (The Condover research was concerned with ex-pupils who are mentally handicapped, rather than mentally ill.)

(2) Rehabilitation of hospital residents with a view to their transfer to:

(3) Adult Training Centres for the Mentally Handicapped in the community, with associated hostels. (Staff of centres hope to transfer a few more able members to open or sheltered employment).

Parallel with (3) are facilities authorised by the National Assistance Act, (1948), for the whole range of non-mentally handicapped people:

(4) Other Day Centres and associated hostels.

(5) Workshops and opportunities for work at home with assistance in the sale of goods produced.

The continuum goes further through the Disabled Persons (Employment) Act, (1944 and 1958). (People who avail themselves successfully of these opportunities can be considered, in the context of my research, to be mildly, not severely handicapped).

(6) Sheltered Workshops with associated training, and residence if necessary.

(7) Training with a view to placement in open industry or placement direct into industry. A number of resettlement officers are available.

At appropriate places in the services listed above, legislation provided for free transport to work, occupation or training; medical and other rehabilitative services; help with leisure, etc.

The above continuum, if it functioned properly, would be a system of which a country could be proud, but the important question is: does it really work well? The answer is that it only functions in part and in a haphazard fashion. There

are a few small technical difficulties, but the main explanation of the disappointing failure of the plan is simple: the serious lack of money.

Social Services and the "Continuum"

I suggest that an important duty of Social Services Departments is to ensure that the system of interlinked facilities should function as a continuum from hospital right through to employment. In practice some Departments are already achieving some of the co-ordination necessary, but I have not encountered any scheme where the idea of a continuum was fully worked out. The nearest approaches to a co-ordinated scheme are the combined Social Centres such as those I have seen in Oldham, Chesterfield and Huddersfield - and there must be others. Such centres ensure co-operation between their staffs, social workers and administrators and I gained the impression of Centres for the Handicapped at the heart of a local community. None of the centres, however, seemed to be co-ordinated with services for the mentally handicapped.

The provision of the new centres and hostels has to await the availability of finance. The co-ordinating of existing services, which would be extended to include new facilities, need involve little or no additional expense and I make the following recommendations.

1. Social Services Departments should set up a system of co-ordinating meetings so that staffs of centres should not feel isolated from the general functioning of the Departments, as often is the case, and so that the progress of individual handicapped people and the general provisions are kept under constant review. The meetings should involve representatives of the staffs of all centres, administrators and social workers who have responsibilities for handicapped people, including hospital social workers and someone who assures liaison with the Disablement Resettlement Service of the Department of Employment and Productivity.

2. Special efforts should be made to co-ordinate A.T.C.s and Other Day Centres by providing a variety of activities, some of which may be of value for the less seriously mentally handicapped and the physically handicapped working together.

3. Where transfer of more able members of both types of day centres to existing Sheltered Workshops is not practicable, special sheltered workshop type departments should form part of the complete day centre system, where work conditions and wages are comparable to the actual sheltered workshop regulations.

4. Opportunities for education, according to individuals' abilities and interests should be provided in day centres, or evening classes or further education programmes, or in a combination of these. Particular attention should be paid to the needs of school leavers and young adults.

Special Needs of Multi-handicapped Blind Adults

1. Many multi-handicapped adults can be wholly integrated into A.T.C.s and Other Day Centres of the type specialising with crippled people, including centres which are sometimes called Work Centres.

2. Although special day centres for blind people with mental handicaps are unnecessary, there is a good case, where local conditions make it feasible, for the assembling of a group of such people within a selected A.T.C.

3. Multi-handicapped blind adults are better placed in centres catering for both blind and for physically handicapped people than in centres for the blind only.

4. When multi-handicapped people show such good practical skills that open or sheltered employment is a possibility, the help of a Blind Persons' Resettlement Officer or of a Placement Officer employed by the R.N.I.B. should be sought.

5. When residence in a hostel becomes possible, most multi-handicapped blind people could manage in a hostel for seeing handicapped people, especially if it is associated with a day centre which they attend.

6. Special units for visually handicapped residents in hospital are required to ensure maximum development of their abilities and independence, but they should be integrated into the general life of the hospital as much as possible. If they are found to be suitable for transfer from hospital, the combined special training and general group life experience would help them to function effectively in community hostels catering for sighted ex-hospital residents.

7. The combining of welfare services for the blind into the services for the handicapped generally, arising from the Local Authority Social Services Act, aroused much controversy. Two opposed schools of thought were: (a) blind people would suffer greatly through deterioration in the services to which they had been accustomed, and, (b) pruning of some frequent and trivial services was necessary so that other types of handicapped people could receive services of which they were urgently in need, and that the pruning would not cause a deterioration in essential services for the blind. On the whole, I was of the second school of thought, but now I see some evidence of a deterioration of services for the blind. The training of technical officers and mobility officers for the blind will go some way towards correcting this deterioration, but more action seems necessary to re-establish, in the Local Authorities which have abandoned it, some centralised arrangements for blind welfare. As far as the "continuum" is concerned, with its emphasis on the integration of many blind people into services for seeing handicapped people, staff of these services need help and guidance from officers with training and experience with the blind.

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Elizabeth Gunn Occupation Centre
Queen Alexandra College
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BRITISH TALKING BOOK SERVICE, Mount Pleasant, Alperton, London. HAO 1RR.

CALDERSTONES HOSPITAL, Whalley, Blackburn, Lancs.

CHESHIRE FOUNDATION (CHESHIRE HOMES), 19, Bolton Street, London. W.1.

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REGIONAL ASSOCIATIONS FOR THE BLIND
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RUSHTON HALL SCHOOL, Near Kettering.
SUNSHINE HOMES (Residential Nursery and Infants Schools) at East Grinstead, Leamington, Northwood, Overley (Condover), Southport and Southerndown, (Near Bridgent).
HEATHERSET VOCATIONAL CENTRE, Gatton Road, Wray Common, Reigate, Surrey.
MOON SOCIETY, Holmesdale Road, Reigate, Surrey.
REHABILITATION CENTRES:
MANOR HOUSE, Middle Lincombe Road, Torquay, Devon.
CLIFTON SPINNEY, Sturgeon Avenue, Clifton, Nottingham. NG11 8NP

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